

DEFENSE HEALTH CARE REFORM

HEARING

BEFORE THE

COMMITTEE ON ARMED SERVICES UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

FEBRUARY 23, 2016



Available via the World Wide Web: <http://www.Govinfo.gov/>

U.S. GOVERNMENT PUBLISHING OFFICE

34-011 PDF

WASHINGTON : 2019

COMMITTEE ON ARMED SERVICES

JOHN McCAIN, Arizona, *Chairman*

JAMES M. INHOFE, Oklahoma	JACK REED, Rhode Island
JEFF SESSIONS, Alabama	BILL NELSON, Florida
ROGER F. WICKER, Mississippi	CLAIRE McCASKILL, Missouri
KELLY AYOTTE, New Hampshire	JOE MANCHIN III, West Virginia
DEB FISCHER, Nebraska	JEANNE SHAHEEN, New Hampshire
TOM COTTON, Arkansas	KIRSTEN E. GILLIBRAND, New York
MIKE ROUNDS, South Dakota	RICHARD BLUMENTHAL, Connecticut
JONI ERNST, Iowa	JOE DONNELLY, Indiana
THOM TILLIS, North Carolina	MAZIE K. HIRONO, Hawaii
DAN SULLIVAN, Alaska	TIM KAINE, Virginia
MIKE LEE, Utah	ANGUS S. KING, JR., Maine
LINDSEY GRAHAM, South Carolina	MARTIN HEINRICH, New Mexico
TED CRUZ, Texas	

CHRISTIAN D. BROSE, *Staff Director*

ELIZABETH L. KING, *Minority Staff Director*

CONTENTS

FEBRUARY 23, 2016

	Page
DEFENSE HEALTH CARE REFORM	1
Loftus, Dr. Bernadette C., Associate Executive Director and Executive-in-Charge for the Mid-Atlantic Permanente Medical Group	4
Fendrick, Dr. A. Mark, Director of the Center for Value-Based Insurance Design and Professor in the Departments of Internal Medicine and Health Management and Policy at the University of Michigan	8
McIntyre, David J., Jr., President and CEO of TRIWEST Healthcare Alliance	18
Whitley, Dr. John E., Senior Fellow at the Institute for Defense Analyses	24
Woodson, Honorable Jonathan, M.D., Assistant Secretary of Defense for Health Affairs	58
Bono, Vice Admiral Raquel C., USN, Director of the Defense Health Agency ...	60
West, Lieutenant General Nadja Y., USA, Surgeon General of the Army and Commanding General U.S. Army Medical Command	69
Ediger, Lieutenant General Mark A., USAF, Surgeon General of the Air Force	75
Faison, Vice Admiral C. Forrest, III, USN, Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery	79
Questions for the Record	92
Appendix A—Additional Statements	
National Military Family Association	117
Cleveland Clinic	136
National Guard Association of the U.S.	141
National Association of Chain Drug Stores	144
The Fleet Reserve Association	151
The Military Coalition	157

DEFENSE HEALTH CARE REFORM

TUESDAY, FEBRUARY 23, 2016

U.S. SENATE,
SUBCOMMITTEE ON PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:31 p.m. in Room SD-G50, Dirksen Senate Office Building, Senator Lindsey O. Graham (chairman of the subcommittee) presiding.

Subcommittee members present: Senators Graham, McCain, Wicker, Tillis, Gillibrand, Blumenthal, and King.

OPENING STATEMENT OF SENATOR LINDSEY O. GRAHAM

Senator GRAHAM. The committee will come to order.

I thank everyone for attending.

We meet this afternoon to discuss military health care system reform and to learn how we can redesign an outdated 20th century health care system that has become unsustainable and does not work as well as it should for service men and women and their families.

We are fortunate to have two panels of distinguished witnesses joining us today.

On the first panel, we have Dr. Bernadette Loftus, Associate Executive Director and Executive-in-Charge for Mid-Atlantic Permanente Medical Group; Dr. Mark Fendrick, Director of the Center for Value-Based Insurance Design and Professor in the Departments of Internal Medicine and Health Management and Policy at the University of Michigan; Mr. David McIntyre, President and CEO [Chief Executive Officer] of the TriWest Healthcare Alliance; Mr. John Whitley, Senior Fellow at the Institute for Defense Analysis.

On the second panel, we have the Honorable Jonathan Woodson, Assistant Secretary of Defense for Health Affairs; Vice Admiral Bono, Director of the Defense Health Agency; Lieutenant General Mark Ediger, Surgeon General of the Air Force; Vice Admiral Faison, Surgeon General of the Navy; Lieutenant General West, Surgeon General of the Army.

Senator McCain has made this a priority of the committee to try to find a way to reform health care. We made a good effort and I think some breakthroughs in terms of retirement reform. Now it is health care's turn because it is such a big part of the budget.

Last year, the Military Compensation and Retirement Modernization Commission gave us an important report on the military compensation and retirement system, complete with numerous rec-

ommendations to modernize that system. Without the commission's great work, we could not have reformed the military retirement system in the comprehensive way that we did. We have more work to do.

The commission also made recommendations to assure servicemembers receive the best possible combat casualty care to improve access, choice and value of health care for all beneficiaries and improve support for family members with special medical needs.

In the NDAA [National Defense Authorization Act] for the fiscal year 2016, we began the journey to accomplish military health system reform by requiring DOD [Department of Defense] to establish and publish appropriate access standards requiring DOD to be more transparent in the important areas of health care quality, patient safety, and beneficiary satisfaction by requiring them to publish outcome measures on public websites, mandating a pilot program that allows TRICARE beneficiaries to get urgent care without needing to get a time-consuming, unnecessary pre-authorization for treatment and requiring the DOD to implement a pilot program on value-based reimbursement whereby health care providers are reimbursed for improving health care economics, outcomes, patient satisfaction, and the experience of care.

Although the commission published this report over 1 year ago, we have seen little progress made by DOD to fix the many problems in their hospitals and clinics. In fact, we continue to get frequent reports of the difficulties military families face every day. Here are two examples.

An expectant mother with a high-risk pregnancy moved with her husband to a new duty station during the 28th week of her pregnancy. Before being assigned to an obstetrician at the new duty station, she had to see her primary care manager and get a pregnancy test, despite the fact that her medical records verified her high-risk status. After going through all of this, she still could not get an appointment with a military obstetrician until the 36th week.

A spouse of a retiree injured her wrist in December and she scheduled an appointment at Walter Reed for an evaluation. At the appointment, the provider spent more time berating the patient for being overweight than examining her wrist. A wrist x-ray was done, but the provider dismissed the wrist injury as a carpal tunnel syndrome. No follow-up appointment was given. One month later, the patient received a letter from the radiology department at Walter Reed advising her that she had a broken wrist. The patient now has a cast on her arm.

In my view, these failures to provide timely quality health care are symptoms of the many ills within the military health care system. Clearly there are problems. There are centers of excellence in the system, but these centers are not large enough and frequent enough. In my view, we have seen a military health care system designed and structured over decades to deliver peacetime health care in a way that is being passed by by time and modernization in the private sector.

On the battlefield, there are many soldiers alive today that would have died in other wars because of the quality of military

health care. That has to be acknowledged. To those on the front line of this fight, you have done amazing things.

The purpose of this committee is to learn about how we can make things better, to listen to the private sector of what works there, and see if we can take a 20th century health care system designed to benefit the bravest among us to have better outcomes, more value, and to make it more sustainable.

With that, I will turn it over to my colleague, Senator Gillibrand, who has been terrific in everything reform.

STATEMENT OF SENATOR KIRSTEN E. GILLIBRAND

Senator GILLIBRAND. Thank you, Senator Graham, for your leadership and the work you do for this committee. I join with you today in welcoming our witnesses as we begin our discussion of military health care reform.

I was pleased to read about the many exciting and good approaches to health care in all of the witnesses' testimony, including Dr. Fendrick's mention of value-based insurance design utilized in my home State of New York and I am looking forward to hearing more about those approaches today.

Last year, the Senate and House Fiscal Year 2016 National Defense Authorization Act conference report included a commitment to work with the Department of Defense to begin reforming the military's health care system. The conference report called the reforms aimed at improving access, quality, and the experience of care for beneficiaries.

Today's hearing is the Senate's first step to fulfilling this agreement. We begin with a panel of experts from outside the Department of Defense to discuss innovations and best practices in health care across the U.S. From this panel, we hope to learn about the possibilities for improving military health care.

The first panel will be followed by a panel of officials in charge of health care for our servicemembers, retirees, and families. From this panel, we expect to hear about current and prospective future initiatives in the military's health care system, as well as their assessment of innovations and best practices described by the witnesses on the first panel.

As we consider changes to the military health care system, it is critical that we ensure that no servicemembers or their families are left behind and that the care we provide accounts for the unique needs of our military community and that any changes we consider improve access, quality, and experience for beneficiaries.

I am particularly interested in hearing about innovations and best practices to address health care of military families with special needs. I am interested in hearing about the private sector's management of pediatric populations with chronic or complex health problems such as those with autism or other developmental disabilities and how we may be able to adapt these practices to serving our military families.

Specifically, many on this committee are aware of my work to ensure that all military children with autism have access to ABA [Applied Behavior Analysis] therapy, which is considered the gold standard treatment to help these kids reach their full potential. I appreciate that the military has put in place a demonstration pro-

gram to help military families, and I am pleased with this program's success.

However, I am worried that the proposed changes to reimbursement rates for ABA therapy providers may derail this program. In your remarks, I would appreciate a discussion of your recommendations and perspectives regarding families with special needs children.

Finally, we have to make sure that our military health care providers maintain the skills and experiences they need to continue to provide world-class health care to our servicemembers wounded on the battlefield, and we have to ensure that those who have served our country bravely return to a health care system that is able to meet their physical and mental health care needs. Our servicemembers, retirees, and their families deserve the highest quality of care.

Again, I thank our witnesses for the time and effort they have put into this important issue.

Senator GRAHAM. Senator McCain?

Chairman MCCAIN. No. Thank you.

Senator GRAHAM. Dr. Loftus, if you would start.

STATEMENT OF DR. BERNADETTE C. LOFTUS, ASSOCIATE EXECUTIVE DIRECTOR AND EXECUTIVE-IN-CHARGE FOR THE MID-ATLANTIC PERMANENTE MEDICAL GROUP

Dr. LOFTUS. Good afternoon, Mr. Chairman and committee members. Thank you for the invitation to be here today. I am Dr. Bernadette Loftus, Executive-in-Charge of the 1,300-physician Mid-Atlantic Permanente Medical Group at Kaiser Permanente.

Kaiser Permanente is the largest private integrated health care delivery system in the United States providing health care services to 10 million members in eight States and the District of Columbia. Kaiser Permanente is a high-performing health system as recognized by the Commonwealth Fund and the National Committee for Quality Assurance, or NCQA. In 2015, only two systems in the entire U.S. received a 5 out of 5 rating from NCQA for both commercial and Medicare patients, and they were Kaiser Permanente of the Mid-Atlantic States and Kaiser Permanente of Northern California. In fact, no Kaiser Permanente plan received lower than a 4.5 out of 5 rating in 2015, a level that only 10 percent of plans achieved nationwide.

We believe attaining excellent outcomes is based on understanding and relentlessly measuring performance so that opportunities for our improvement are continuously identified. We strategically exploit the full benefits of our electronic medical record, creating systems of care that make it easy to do the right thing and hard to do the wrong. This is accompanied by clear expectations around behavioral norms and performance for our physicians and staff. The reliable achievement of better results starts with knowledge of current results. We measure all aspects of our care at all levels. We choose metrics for measurement that are evidence-based, nationally recognized, and reasonably comparable across geographies and populations. This minimizes distracting arguments that my patients are so unique, you cannot hold me accountable for any particular outcome. We do believe we can fairly assess per-

formance across diverse populations using these standard measures.

We assiduously measure access to care because, obviously, without access, quality suffers. We have learned from 2 decades of studying correlations between patient satisfaction and the objective speed to access in days that patients have a much higher standard for access than doctors may feel is strictly medically necessary. Because of this, we base our access standards solely on our members' expectations. Our best levels of patient satisfaction with routine specialty care, for example, correlate with a speed to access of significantly less than 10 days from date of referral. We measure and report access to care daily. The expectation for physician managers is that the supply of appointments will be managed dynamically on a daily basis to adjust to the ebb and flow of demand.

The science of excellent access is just that, a science, although it is a relatively simple one. Supply of available appointments must always exceed historical demand in order to ensure great access. Hence, our physician managers are thoroughly trained on the constant management that must be brought to bear to maintain access.

High achievement in quality requires the same degree of performance measurement, analytics, and reporting. Specific to quality management, we produce monthly variation reports, which graphically display variation in performance on quality metrics on multiple levels. These unblinded reports allow us to identify the high and low performers in similarly situated practices, and this creates the opportunity for dialogue around improvement. Data transparency spurs not only dialogue, but a little competition as well, which in turn engenders more rapid improvement. Data is delivered directly to every physician's desktop. Our primary care physicians can, on a daily basis, check their own performance on quality measures against those of others in their department.

We do not, however, leave prevention and quality achievement solely to our primary care physicians. It is our cultural expectation that every physician, regardless of specialty, addresses the prevention and chronic disease needs of every patient she sees. This means that dermatologists and orthopedic surgeons are as responsible for ensuring that each diabetic gets his hemoglobin A1c measured timely or that a woman gets her mammogram that is due, as are those patients' primary care physicians. We continually collect and analyze data about our patients' health status and other findings and use that to create extensive population health registries that in turn inform decision support software in our EMR [Electronic Medical Records] so that every physician is alerted at every visit to every patient that is due for a prevention or treatment measure. We believe high achievement of quality is everyone's job.

Again, thank you for today's invitation. I hope the information provided about Kaiser Permanente will be useful to you as you consider changes to the military health system and the TRICARE program. Kaiser Permanente would be honored to provide further assistance to you in the future and to serve this population in any way we can.

[The prepared statement of Dr. Loftus follows:]

PREPARED STATEMENT BY DR. BERNADETTE LOFTUS

Subcommittee Chairman Graham, Ranking Member Gillibrand, and Members of the Committee, thank you for the invitation to testify today. I am Dr. Bernadette Loftus, Executive-in-Charge of the Mid-Atlantic Permanente Medical Group at Kaiser Permanente. As you continue your efforts to build and maintain a top performing health care delivery system for the women and men of our armed services and their families, Kaiser Permanente is pleased to support you and the leaders of the Military Health System.

INTRODUCTION AND BACKGROUND

Kaiser Permanente is the largest private integrated healthcare delivery system in the U.S., with 10.3 million members in eight states and the District of Columbia. We are committed to providing high-quality, affordable health care services and improving the health of our members and the communities we serve. Our roots date back to 1945. Our model was born out of the innovation and ingenuity that mobilized our nation for World War II when Henry J. Kaiser and Dr. Sidney Garfield teamed up to provide medical care for tens of thousands of workers building ships around the clock for the war effort.

Today, Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 38 hospitals and over 600 other clinical facilities; and the Permanente Medical Groups, which are multi-specialty group practices employing over 18,000 physicians that contract with Kaiser Foundation Health Plan to provide or arrange health care services for Kaiser Permanente's members. Kaiser Permanente operates in California, Hawaii, Oregon, Washington, Colorado, Georgia, Maryland, Virginia and the District of Columbia. Many of our service areas include a significant presence of military personnel and families.

Kaiser Permanente is honored and grateful to have many former career military and military-trained physicians, nurses, and other clinicians working in our system, including some who remain Active in the Reserves. The training and practice environment of the Military Health System, as well as the values and mission-driven spirit of the women and men who join the Military Health System, produce clinicians who succeed in, and help lead our system. We also appreciate the ongoing opportunities our clinical and operational leaders have to collaborate with leaders in the Military Health System to share best practices and learn from one another.

ALIGNING INCENTIVES FOR HIGH-PERFORMING INTEGRATED HEALTH CARE DELIVERY

Kaiser Permanente's integrated model of care is based on prepayment rather than the volume-driven, fee-for-service reimbursement that dominates U.S. health care. Our integrated delivery system is also characterized by the direct operation of state-of-the-art inpatient and outpatient facilities, pharmacies, and diagnostic and laboratory services. Care is delivered primarily by our contracted multi-specialty physician groups and clinical staff employed by our physician groups, hospitals, and health plans in each of our regions.

By combining care and coverage in an integrated system, our physicians are able to prioritize prevention and population health, while also delivering high quality complex and acute care. Kaiser Foundation Hospitals and Health Plan's not-for-profit governance structure means our financial margins are reinvested in care infrastructure and care transformation, health information technology, research, workforce training, and the support of community health and community benefit.

Our advanced electronic medical record, called KPHealthConnect®, allows our clinicians to collaborate in teams, share information securely, and reduce duplicative testing. It also provides longitudinal tracking of our members' health, and supports our robust quality improvement programs. The member-facing component of our electronic health record, My Health Manager, allows members to exchange secure email with their care team, schedule appointments, get test results, and request prescription refills online. These features are also incorporated in our mobile "app" to provide more ways for our members to connect with us and manage health needs. In 2014, Kaiser Permanente members sent more than 20 million secure emails to their providers.

DELIVERING HIGH-QUALITY CARE

Kaiser Permanente is a high performing health system as recognized by the Commonwealth Fund and the National Committee for Quality Assurance (NCQA). In 2015, only two systems in the entire U.S. received a "perfect" 5 out of 5 rating from

NCQA for both commercial and Medicare patients, and they were Kaiser Permanente of the Mid-Atlantic States, and Kaiser Permanente of Northern California. In fact, no Kaiser Permanente plan received lower than a 4.5 out of 5 rating in 2015, a performance level that only 10 percent of all plans nationwide achieved.

At Kaiser Permanente, we believe that achievement of excellent outcomes is based on understanding and relentlessly measuring current performance, so that opportunities for improvement are continuously identified. We strategically exploit the full benefits of a uniform system-wide electronic health record, which we use to create systems of care that make it easy to do the right thing, and hard to do the wrong. This is accompanied by crystal-clear expectation around behavioral norms and performance of our physicians and staff.

A COMMITMENT TO MEASURING QUALITY AND ACCESS

No health care delivery system can reliably achieve better results unless it knows its current results. At Kaiser Permanente, we measure all aspects of our care delivery at an individual, local, regional, and national level. We choose measures that are evidence-based, nationally-recognized, and reasonably comparable across geographies and populations. This is to minimize the distracting argument that goes like this: “my patients are unique, therefore I cannot be held accountable to achieve any particular measurement or outcome.” In recognition that some patients are sicker than others, we do employ standard risk-adjustment methodologies where appropriate, primarily with inpatient quality measures. As a result of our measurement philosophy, we spend a lot of time on HEDIS (Healthcare Effectiveness Data and Information Set) measures,¹ Consumer Assessment of Health Plans and Systems (CAHPS)² satisfaction measures, and their inpatient twin, HCAHPS (both developed by the Agency for Healthcare Research and Quality), and The Joint Commission core and ÖRYX (Care Measures) measures.³ We feel confident that we can fairly assess performance, down to the individual practitioner level, across diverse populations using these measures.

We also assiduously measure access to care, because there is no quality of care unless there is first access to care. We have learned from over two decades of studying the correlation between patient satisfaction and our objective speed-to-access in days, that patients have a much higher speed-to-access in days than physicians generally feel is medically necessary. Because of this, we set our internal access standards based on our members’ expectations. Our best levels of patient satisfaction with routine specialty access, for example, correlate with a speed-to-access of less than ten calendar days from date of referral. We measure and report access in primary care on a daily basis. The expectation for physician managers is that the supply of appointments in primary care will be managed dynamically on a daily basis to adjust to the ebb and flow of demand. We measure and report specialty access weekly, and expect responsible managers to take action to augment appointment supply when our predictive models indicate the likelihood that access will not meet our standards.

The science of excellent access is just that, a science, although it is a relatively simple one. The supply of available appointments must always exceed historical demand for appointments, in order to ensure great access, and so our physician managers are trained and retrained on the constant management that must be brought to bear to maintain access.

Advances in technology enable us to augment face-to-face appointment access with secure email communications between patients and their physicians, and now video visits. Our prepaid model allows us to adopt these technologies to create capacity for expanded access using the most clinically appropriate, convenient options for our patients. We currently offer video visits through our clinical advice call centers, which operate 24 hours a day, and we are rolling out the option of telehealth visits in primary care and many specialties across our regions. As a data-driven system, we are collecting data and evaluating patient outcomes as we expand these virtual services. Early results show our members value these new modalities of care.

High achievement in quality requires the same degree of performance measurement, analytics, and reporting. Specific to quality management, we produce monthly “variation” reports, which display, with clear graphics, the variation in performance on key quality metrics between departments on those same measures. These unblinded reports allow us to identify the high and low individual performers in similarly situated practices, and this creates the opportunity for dialogue around im-

¹<http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx>

²<https://cahps.ahrq.gov/>

³<http://www.jointcommission.org/accreditation/performance—measurementoryx.aspx>

provement. Data transparency spurs not only dialogue, but a little competition as well, which in turn engenders more rapid improvement. Data literally is delivered to every physician's desktop. Our physicians are able to check their own performance on quality measures against those of others in their department on a daily basis.

EMPHASIZING PREVENTION AND MANAGING CHRONIC CONDITIONS

At Kaiser Permanente, prevention and quality is everyone's responsibility. We do not leave it up to our primary care physicians alone. It is our cultural expectation that every physician, regardless of specialty, will address the prevention and chronic disease measures for every patient she sees. This means that dermatologists and orthopedic surgeons are as responsible for ensuring that each patient with diabetes gets his HgbA1c (Glycated Hemoglobin) measured at the appropriate interval, or that a woman gets her screening mammogram that may be due, as are those patients' primary care physicians. We continually collect and analyze data about our patients' health status, and lab, imaging, and other test results, and use that information to create extensive population health registries. These registries inform decision support software in our electronic health record. As a result, every physician—primary care or specialist—is alerted at every visit to every patient who is due or overdue for prevention or treatment measures.

Patients with chronic conditions (i.e. diabetes, asthma, congestive heart failure, and hypertension) often require the most resources. By stratifying patients according to diagnosis and need, effective disease management programs are seamlessly integrated into our care models, with features that include dedicated case managers, teams that include nurses, social workers, dietitians, and pharmacists, and clinical practice guidelines and decision-support tools. By making the right thing easy to do, our goal is to provide care that is safe, reliable, effective, and equitable.

CONCLUSION

Once again, thank you for inviting me to testify before the Senate Armed Services Committee today on behalf of Kaiser Permanente. I hope that the information provided will be useful to you as you consider possible changes to the Military Health System and the Tricare program. Kaiser Permanente would be honored to provide further assistance to you in the future, and to serve the men and women of the U.S. Military and their families in any way we can.

STATEMENT OF DR. A. MARK FENDRICK, DIRECTOR OF THE CENTER FOR VALUE-BASED INSURANCE DESIGN AND PROFESSOR IN THE DEPARTMENTS OF INTERNAL MEDICINE AND HEALTH MANAGEMENT AND POLICY AT THE UNIVERSITY OF MICHIGAN

Dr. FENDRICK. Good afternoon and thank you, Chairman McCain, Chairman Graham, Ranking Member Gillibrand, and members of the subcommittee. I am Mark Fendrick, a primary care physician and professor at the University of Michigan.

Mr. Chairman, I applaud you for holding this hearing on defense health care reform because access to quality care and containing costs are among the most pressing issues for our military personnel and our national well-being.

Yet, moving from a volume-driven to value-based delivery system requires a change in both how we deliver care and how we engage consumers to seek care. Reforming care delivery and payment policies are important, as you just heard. However, less attention is paid to how we can alter consumer behavior. Today I propose that clinically driven consumer incentives, through the creation of benefit designs that promote smarter decision-making, can assist us in achieving our clinical and financial goals.

The most common approach used by payers to impact consumers in the United States is cost-shifting. With some notable exceptions, most health plans, including TRICARE, implement cost-sharing in

a one-size-fits-all way, in that beneficiaries are charged the same for every doctor visit, every diagnostic test, and every prescription drug.

People frequently ask me if TRICARE members' co-payments are too high, too low, or just right. The answer, of course, is it depends. Asking TRICARE members to pay more for all services, despite clear differences in clinical value, results in decreases in both non-essential and essential care, which in certain clinical circumstances lead to adverse health outcomes and higher overall costs. I see this approach as pennywise and pound foolish.

Does it make sense to you, Mr. Chairman, that my TRICARE patients pay the same out-of-pocket cost for essential visits such as a cardiologist after a heart attack or a therapist for opioid addiction or autism? They pay the same amount to see a dermatologist for mild acne. They pay the same for drugs that are lifesaving for cancer, diabetes, and depression as drugs that make their toenail fungus go away or their hair grow back.

Realizing that TRICARE members avail themselves to too little high-value care and too much low-value care, we endorse smarter, clinically nuanced cost-sharing as a potential solution, one that encourages TRICARE members to use more of the services that make them healthier and discourages them away from the services that do not. We refer to these plans that use clinical nuance as value-based insurance design, or V-BID. V-BID simply sets cost-sharing to encourage the use of high-value services and providers and discourages the use of low-value care.

For the record, I support high cost-sharing levels but only for those services that do not make TRICARE members healthier. The fundamental idea of buy more of the good stuff and less of the bad stuff has made V-BID one of the very, very few health care reform ideas with broad multi-stakeholder and bipartisan political support. Led by the private sector, V-BID has been implemented by hundreds of private and public employers, several States, and most recently the Medicare program. It is common sense. When barriers to high-value services are reduced and access to low-value services are discouraged, we attain more health for every dollar.

Therefore, I recommend incorporating V-BID into TRICARE plans in the following ways.

First, TRICARE plans should vary cost-sharing for services in accordance to who provides them, such as high-performing providers, as Dr. Loftus mentioned, or the location of care based on quality, as well as cost.

Second, TRICARE plans should implement V-BID programs that combine reductions in high-value services but also include increases in cost-sharing for low-value care. As we think about fiscal sustainability, it is important to point out that immediate and substantial savings are accumulated from waste identification and elimination.

Last, TRICARE plans should vary cost-sharing based on information such as clinical risk factors, special needs, and disease diagnosis.

The successful practice of precision medicine requires precision benefit design. As cost-sharing becomes a necessity for TRICARE's fiscal sustainability, I encourage this committee to take a common

sense approach of setting member co-payments based on whether a clinical service makes a TRICARE member healthier instead of the status quo, which is basing contributions exclusively on what they cost. If such an approach encourages the utilization of high-value care and discourages only low-value services, these TRICARE plans can improve health, enhance consumer responsibility, and reduce costs.

I am honored to support the men and women of the U.S. military and their families and am happy to provide the committee further assistance. Thank you very much.

[The prepared statement of Dr. Fendrick follows:]

PREPARED STATEMENT BY DR. A. MARK FENDRICK

Good morning and thank you, Chairman Graham, Ranking Member Gillibrand, and Members of the Subcommittee. I am Mark Fendrick, Professor of Internal Medicine and Health Management & Policy at the University of Michigan. I am addressing you today, not as a representative of the University, but as a practicing primary care physician, a medical educator, and a public health professional. I have devoted much of the past two decades to studying the United States health care delivery system, and founded the University's Center for Value-Based Insurance Design [www.vbidcenter.org] in 2005 to develop and evaluate insurance plans designed to engage consumers, optimize the health of Americans and ensure efficient expenditure of our public and private health care dollars.

Mr. Chairman, I applaud you for holding this hearing on Defense Health Care Reform, because access to quality care and containing costs are among the most pressing issues for our military personnel and our national well-being and economic security. We are well aware that the U.S. spends far more per capita on health care than any other country, yet lags behind other nations that spend substantially less, on key health quality and patient-centered health measures. Since there is consistent agreement within both political parties, and among key stakeholders, that there is already enough money being spent on health care in this country, I would like to emphasize that if we reallocated our existing dollars to clinical services for which there is clear evidence for improving health and away from those that don't, we could significantly enhance quality and substantially reduce the amount we spend. Thus, instead of the primary focus on how much we spend—I suggest we shift our attention to how well we spend our military health care dollars.

FROM A VOLUME-DRIVEN TO VALUE-BASED SYSTEM

Moving from a volume-driven to value-based military health delivery system requires a change in both how we pay for care (supply side initiatives) and how we engage consumers to seek care (demand side initiatives). Previous discussions and earlier testimonies focused on the critical importance and progress regarding reforming care delivery and payment policies. Many sections of the 2016 National Defense Authorization Act (NDAA) address payment issues; Sec. 726 explicitly calls for a pilot program to test value-based reimbursement in TRICARE.

These are important and worthy conversations. Yet, less attention has been directed to how we can alter consumer behavior as a policy lever to bring about a more efficient delivery system. While you have heard about the potential of pay-for-performance programs, patient-centered medical homes, bundled payment models, and other initiatives to influence providers, today I propose that value-driven consumer incentives—through benefit design reforms that promote smart decisions and enhanced personal responsibility—must be aligned with payment reform initiatives for us to achieve our clinical and financial goals for military health care. I commend the Subcommittee for exploring this matter today.

DANGERS OF A BLUNT APPROACH TO BENEFICIARY COST-SHARING—THE IMPORTANCE OF 'CLINICAL NUANCE'

Over the past few decades, public and private payers—including the TRICARE program—have implemented multiple managerial tools to constrain health care cost growth with varying levels of success. The most common approach to directly impact consumer behavior is consumer cost shifting: requiring beneficiaries to pay more in the form of higher premiums and increased cost-sharing for clinician visits, diagnostic tests and prescription drugs. Of note, the Defense Department budget pro-

posal for 2017 calls for increasing the member out-of-pocket contributions for TRICARE members, most dramatically for military retirees under 65.

With some notable exceptions, most U.S. health plans—including TRICARE—implement cost-sharing in a ‘one-size-fits-all’ way, in that beneficiaries are charged the same amount for every doctor visit, diagnostic test, and prescription drug [within a specified formulary tier]. People frequently ask me whether the amount of cost-sharing faced by TRICARE members is too high, too low, or just right. The answer, of course, is “it depends.” As TRICARE members are asked to pay more for every clinician visit and for every prescription—despite clear differences in health produced—a growing body of evidence demonstrates that increases in patient cost-sharing lead to decreases in the use of both non-essential and essential care. Unfortunately, research suggests that increasing ‘skin in the game’ has not produced a savvier health care consumer.

A noteworthy example of the undesirable impact of ‘one-size-fits-all’ *increases* in cost-sharing is a New England Journal of Medicine study that examined the effects of increases in copayments for all doctor visits for Medicare Advantage beneficiaries [Trivedi A. N Engl J Med. 2010;362(4):320-8]. As expected, individuals who were charged more to see their physician(s) went less often; however, these patients were hospitalized more frequently and *their total medical costs increased*. While this blunt approach may reduce TRICARE expenditures in the short-term, lower use rates of essential care may lead to inferior health outcomes and higher overall costs in certain clinical circumstances. This effect simply demonstrates that the age-old aphorism ‘penny wise and pound foolish’ applies to health care.

Conversely, *decreases* in cost-sharing applied to all services regardless of clinical benefit—which may have been the case in certain TRICARE plans—can lead to overuse or misuse of services that are potentially harmful or provide little clinical value. For the record, I support high cost-sharing levels for those services—but *only those services*—that do not make TRICARE members healthier. That said, I don’t think it makes sense to raise cost-sharing on the services I beg my patients to do, such as fill their prescriptions to manage their chronic conditions (e.g. diabetes, depression, HIV) and laboratory tests that allow the monitoring of a specific disease (e.g., cholesterol, blood sugar).

Since there is evidence of both underuse of high-value services and overuse of low-value services in the TRICARE program, ‘*smarter*’ cost-sharing is a potential solution—one that encourages TRICARE members to use more of those services that make them healthier, and discourages the use of services that do not. Therefore, to more efficiently reallocate TRICARE medical spending and optimize health, the basic tenets of *clinical nuance* must be considered. *These tenets recognize that: 1) clinical services differ in the benefit provided; and 2) the clinical benefit derived from a specific service depends on the patient using it, who provides it, and where it is provided.*

Does it make sense to you, Mr. Chairman, that my TRICARE patients pay the same copayment to see a cardiologist after a heart attack as to see a dermatologist for mild acne—Or that the prescription drug copayment is the same amount for a lifesaving medication to treat diabetes, depression, or cancer, as it is for a drug that treats toenail fungus—On the less expensive generic drug tier available to most TRICARE members (current copayments are \$10 at retail pharmacies and \$0 through a mail order pharmacy), certain are drugs so valuable that I often reach into my own pocket to help patients fill these prescriptions; while for the same price there are also drugs of such dubious safety and efficacy, I honestly would not give them to my dog. The current ‘one-size-fits-all’ cost-sharing model lacks clinical nuance, and frankly, to me, makes no sense. As we deliberate Defense Health Care benefit redesign, there is bipartisan recognition that the current structure of the TRICARE benefit is outdated, confusing, and in need of reform. Taking steps to improve the current array of confusing deductibles, copayments and coinsurance is long overdue. I could not agree more that our military personnel deserve better. Only after we acknowledge the limitations and inefficiencies of the TRICARE cost-sharing structure, can we identify ways to improve it. It is my impression that TRICARE members avail themselves of too little high-value care and too much low-value care. Precision medicine needs precision benefit design. We need benefit designs that support consumers in obtaining evidence-based services such as diabetic retinal exams and discourage individuals through higher cost-sharing from using dangerous or low-value services such as those identified by professional medical societies in the Choosing Wisely initiative. By incorporating greater clinical nuance into benefit design, payers, purchasers, beneficiaries, and taxpayers can attain more health for every dollar spent.

VALUE-BASED INSURANCE DESIGN [V-BID]: IMPLEMENTING CLINICAL NUANCE

Realizing the lack of clinical nuance in available public and commercial health plans, more than a decade ago the private sector began to implement clinically nuanced plans based on a concept our team developed known as Value-Based Insurance Design, or V-BID. *The basic V-BID premise calls for reducing financial barriers to evidence-based services and high-performing providers and imposing disincentives to discourage use of low-value care.* A V-BID approach to benefit design recognizes that different health services have different levels of value. It's common sense—when barriers to high-value treatments are reduced and access to low-value treatments is discouraged, these plans result in better health with the potential to substantially lower spending levels.

Let me be clear, Mr. Chairman, I am not asserting that implementing V-BID into TRICARE is a single solution to TRICARE's problems. If we are serious about improving our members' experiences and health outcomes, while also bending the health care cost curve, we must change the incentives for consumers as well as those for providers. *Blunt changes to TRICARE benefit design—such as those recently announced—must not produce avoidable reductions in quality of care.* Instead, I would recommend clinically driven—instead of a price driven—strategies.

I'm pleased to tell you that the intuitiveness of the V-BID concept is driving momentum at a rapid pace in both the private and public sectors, and we are truly at a 'tipping point' in its adoption. Hundreds of private self-insured employers, public organizations, non-profits, and insurance plans have designed and tested V-BID programs. The fundamental idea of 'buy more of the good stuff and less of the bad' has made V-BID one of the very few health care reform ideas with broad multi-stakeholder and bipartisan political support.

V-BID implementation has occurred in many of the states represented by members of this subcommittee. Mr. Chairman, V-BID principles have been implemented in your State of South Carolina Medicaid program to ensure that vulnerable beneficiaries have better access to potentially life-saving drugs used to treat chronic diseases. Senator Gillibrand, the Empire state has highlighted V-BID in Governor Cuomo's state innovation plan and is a key element of the State Innovation Model (SIM) program. Senator King, V-BID has a similar high profile role in the Maine SIM program. Senator Cotton, Arkansas has been a national leader in aligning consumer engagement initiatives with the episode-based payment model. Senators Tillis and Blumenthal, V-BID plans are now offered to state employees in North Carolina and Connecticut. Of note, the Connecticut Health Enhancement Plan—a V-BID plan for state employees—has demonstrated high levels of participation in healthy behaviors (98 percent), and preventive care, and has significantly reduced emergency room visits in only two years. This plan has become a national model used by several other states and public employers.

The last and most important example I would like to mention is the implementation of V-BID in the Medicare program, a crucial component of our nation's commitment to take care of the elderly and disabled among us. The 'one-size-fits-all' approach to Medicare coverage dates back to its inception in the 1960s, driven by discrimination concerns. Over the past several years, bipartisan, bicameral Congressional support has grown to allow Medicare to implement clinically nuanced benefit designs. In 2009, Senators Hutchison and Stabenow introduced a bipartisan bill, "Seniors' Medication Copayment Reduction Act of 2009" (S 1040), to allow a demonstration of V-BID within Medicare Advantage plans. Last May, Senators Thune and Stabenow introduced the "Value-Based Insurance Design Seniors' Copayment Reduction Act of 2015" (S 1396). A companion bill included in the "Strengthening Medicare Advantage through Innovation and Transparency for Seniors Act of 2015" (HR 2570) passed the U.S. House of Representatives in June with strong bipartisan support.

This strong Congressional backing led the Center for Medicare & Medicaid Innovation (CMMI) to announce a program to test V-BID in Medicare Advantage (MA) plans in September 2015. The 5-year demonstration program will examine the utility of structuring patient cost-sharing and other health plan design elements to encourage patients to use high-value clinical services and providers, thereby improving quality and reducing costs. The model test will begin in January 2017, in Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee.

INFUSING 'CLINICAL NUANCE' INTO TRICARE

Flexibility in benefit design would allow TRICARE plans to achieve even greater efficiency and to encourage personal responsibility among members in the following ways:

I. Differential Cost-Sharing for use of Different Providers or Settings

Since the value of a clinical service may depend on the specific provider or the site of care delivery, *TRICARE plans should have the flexibility to vary cost-sharing for a particular outpatient service in accordance with who provides the service and /or where the service is delivered.* This flexibility is increasingly feasible, as quality metrics and risk-adjustment tools become better able to identify high-performing health care providers and/or care settings that consistently deliver superior quality.

II. Differential Cost-Sharing for use of Different Services

To date, most clinically nuanced designs have focused on lowering patient out-of-pocket costs for high-value services (carrots). These are the services I beg my patients to do—for which there is no question of their clinical value—such as immunizations, preventive screenings, and critical medications and treatments for individuals with chronic disease such as asthma, diabetes, and mental illness (e.g. as recommended by National Committee for Quality Assurance, National Quality Forum, professional society guidelines). Despite unequivocal evidence of clinical benefit, there is substantial underutilization of these high-value services by TRICARE members. Multiple peer-reviewed studies show that when patient barriers are reduced, compliance goes up, and, depending on the intervention or service, total costs go down.

Yet, from the TRICARE program’s perspective, the cost of incentive-only ‘carrot-based’ V-BID programs depends on whether the added spending on high-value services is offset by a decrease in adverse events, such as hospitalizations and visits to the emergency department. While these high-value services are cost-effective and improve quality, many are not cost saving—particularly in the short term. However, research suggests that non-medical economic effects—such as the improvement in productivity associated with better health—can substantially impact the financial results of V-BID programs.

While significant cost savings are unlikely with incentive-only ‘carrot’ programs in the short term, *a V-BID program that combines reductions in cost-sharing for high-value services and increases in cost-sharing for low-value services can both improve quality and achieve net cost savings.* Removing harmful and/or unnecessary care from the system is essential to reduce costs, and creates an opportunity to improve quality and patient safety. Evidence suggests significant opportunities exist to save money without sacrificing high-quality care. For example, in 2014, the lowest available estimates of waste in the U.S. health care system exceeded 20 percent of total health care expenditures. Though less common, some V-BID programs are designed to discourage use of low-value services and poorly performing providers. Low-value services result in either harm or no net benefit, such as services labeled with a D rating by the U.S. Preventive Services Task Force.

It is important to note that *many services that are identified as high quality in certain clinical settings are considered low-value when used in other patient populations, clinical diagnoses or delivery settings.* For example, cardiac catheterization, imaging for back pain, and colonoscopy can each be classified as a high- or low-value service depending on the clinical characteristics of the person, when in the course of the disease the service is provided, and where it is delivered.

Fortunately, there is growing movement to both identify and discourage the use of low-value services. The ABIM [American Board of Internal Medicine] Foundation, in association with Consumers Union, has launched Choosing Wisely, an initiative where medical specialty societies identify commonly used tests or procedures whose necessity should be questioned and discussed. Thus far, over 40 medical specialty societies have identified at least five low-value services within their respective fields. Substantial and immediate cost savings are available from waste identification and elimination. Thus, *V-BID programs that include both ‘carrots’ and ‘sticks’ may be particularly desirable in the setting of budget shortfalls.*

III. Differential Cost-Sharing for Certain Services for Specific Enrollees

Since a critical aspect of clinical nuance is that the value of a medical service depends on the person receiving it, we recommend that TRICARE plans encourage differential cost-sharing for specific groups of enrollees. *The flexibility to target enrollee cost-sharing based on clinical information (e.g., diagnosis, clinical risk factors, etc.) is a crucial element to the safe and efficient allocation of expenditures.* Under such a scenario, a plan may choose to exempt certain enrollees from cost-sharing for a specific service on the basis of a specific clinical indicator, while imposing cost-sharing on other enrollees for which the same service is not clinically indicated. Under

such an approach, plans can recognize that many services are of particularly high-value for beneficiaries with conditions such as diabetes, hypertension, asthma, and mental illness, while of low-value to others. (For example, annual retinal eye examinations are recommended in evidence-based guidelines for enrollees with diabetes, but not recommended for those without the diagnosis.) Without easy access to high-value secondary preventive services, previously diagnosed individuals may be at greater risk for poor health outcomes and avoidable, expensive, acute-care utilization. Conversely, keeping cost-sharing low for all enrollees for these services, regardless of clinical indicators, can result in overuse or misuse of services leading to wasteful spending and potential for harm.

Permitting ‘clinically nuanced’ variation in cost-sharing would give TRICARE plans a necessary tool needed to better encourage members to receive high-value services. This addition would eliminate many of the challenges and limitations of the ‘one-size-fits-all’ model.

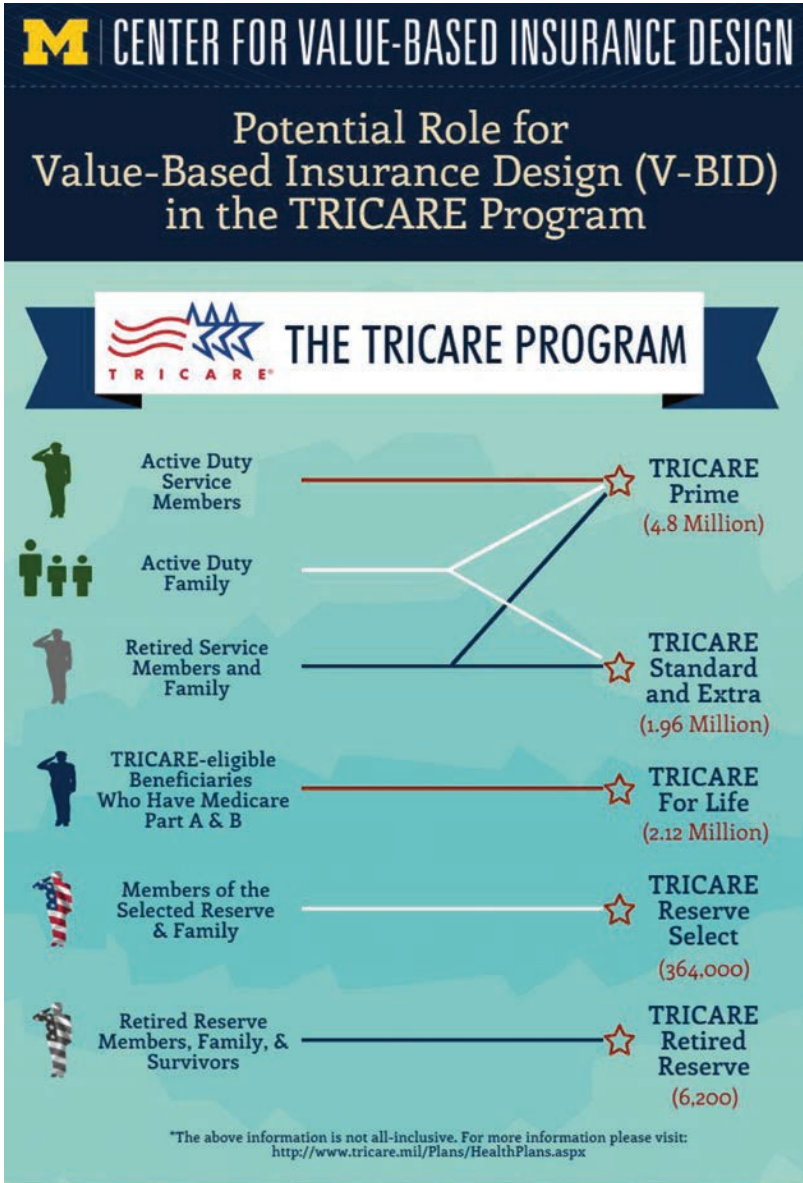
ALIGNMENT OF CONSUMER ENGAGEMENT WITH ALTERNATIVE PAYMENT MODELS

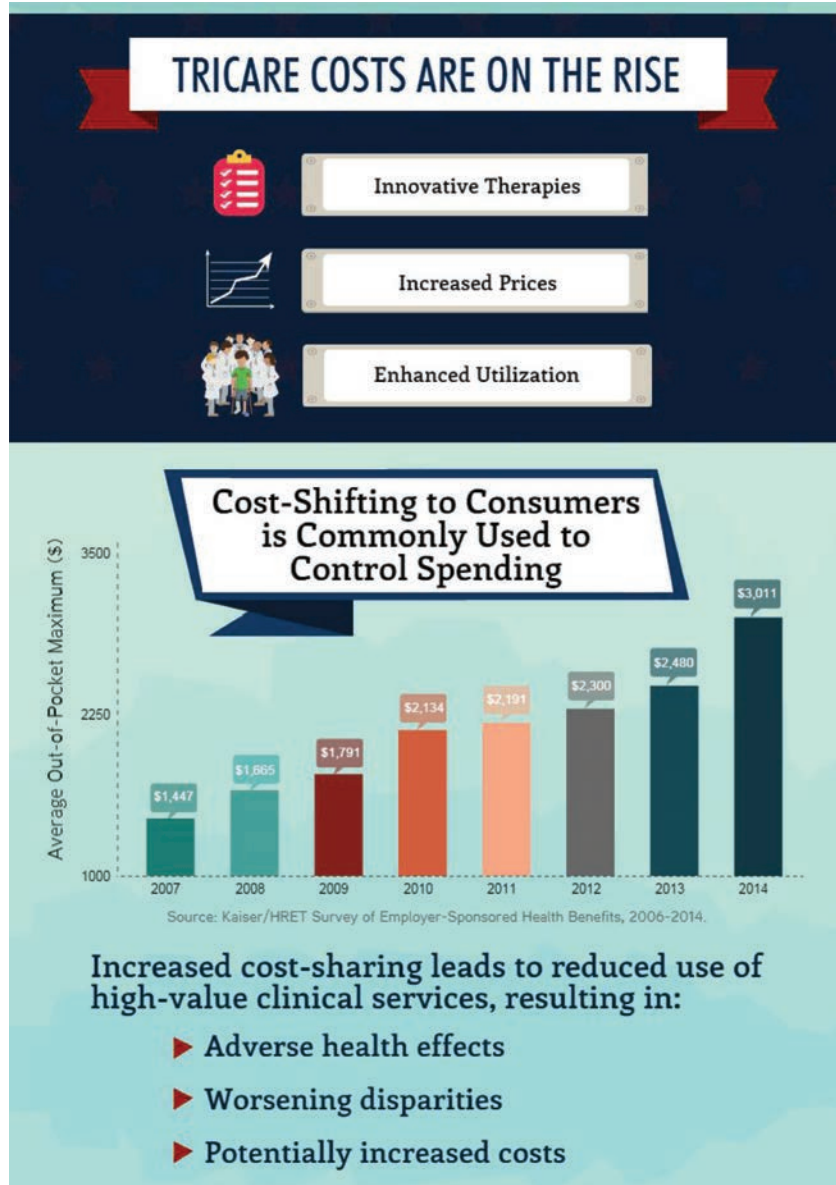
The TRICARE program is currently examining many exciting, some unproven, value-based reimbursement initiatives such as bundled payments, pay-for-performance, and patient-centered medical homes, some of which are explicitly addressed in the 2016 National Defense Authorization Act. As these initiatives provide incentives for clinicians to deliver specific services to particular patient populations, it is of equal importance that consumer incentives are aligned. As a practicing physician, *it is incomprehensible to realize that my patients’ insurance coverage may not offer easy access for those exact services for which I am benchmarked.* Does it make sense to offer a financial bonus to get my patient’s diabetes blood sugar under control, when her benefit design makes it prohibitively expensive to fill her insulin prescription or provide the copayment for her eye examination? *The alignment of clinically nuanced, provider-facing, and consumer engagement initiatives is a necessary and critical step to improve quality of care, enhance the member experience, and contain cost growth for the TRICARE program.*

CONCLUSION

As this committee considers changes to the TRICARE benefit design, it is an honor for me to present one novel approach to better engage TRICARE members. As a practicing clinician, I believe that the goal of the military health system is to keep its members healthy, not to save money. That said, I strongly concur that health care cost containment is absolutely critical for the sustainability of the TRICARE program and our nation’s fiscal health. While there is urgency to bend the health care cost curve, cost containment efforts should not produce avoidable reductions in quality of care. As cost-sharing becomes a necessity for fiscal sustainability, I encourage you to take a common-sense approach of setting member co-payments on whether a clinical service makes a TRICARE member healthier—instead of the current strategy of basing member contributions on the price of the service. *In other words, make it harder to buy the services they should not be using in the first place.* If such principles encourage the utilization of high-value providers and services and discourage only low-value services, TRICARE plans can improve health, enhance consumer responsibility, and reduce costs.

Thank you.





A Potential Solution: Clinical Nuance

What is
clinical
nuance?

Services differ in clinical benefit produced



Clinical benefits from a specific
service depend on:



Value-Based Insurance Design

Sets cost-sharing to encourage greater
utilization of high-value services and providers
and discourage use of low-value care

V-BID Impact

- Bipartisan political support
- Multi-stakeholder endorsement
- Implemented by hundreds of public and private organizations
 - Enhances access to preventive care for 137 million Americans
 - CMS implements MA V-BID model test in 7 states

TRICARE plans...	V-BID plans...
Increase out-of-pocket costs	Promote efficient expenditures
Offer one-size-fits-all cost-sharing	Increase use of high-value services and providers
Limit provider access	Enhance clinical outcomes
Misalign consumer and provider incentives	Align with provider initiatives

M | CENTER FOR VALUE-BASED INSURANCE DESIGN

University of Michigan V-BID Center
2800 Plymouth Road, Bldg 16, 4th Floor
Ann Arbor, MI 48109-2800

Phone: 734.647.9688
Email: vbidcenter@umich.edu
Web: vbidcenter.org

Twitter: @um_vbid
Facebook: www.facebook.com/umvbid
LinkedIn: Center for Value-Based Insurance Design

**STATEMENT OF DAVID J. MCINTYRE, JR., PRESIDENT AND CEO
OF TRIWEST HEALTHCARE ALLIANCE**

Mr. MCINTYRE. Good afternoon, Chairman McCain, Chairman Graham, Ranking Member Gillibrand, and members of the Personnel Subcommittee of the Senate Armed Services Committee.

It is a privilege to appear before you today at this initial hearing on defense health care reform, and I hope that my participation in today's hearing will be of assistance to you and the Defense Department as you seek to ensure that the military health system is strengthened and is able to continue to provide optimal support to those who wear the cloth of this Nation, their families, and those who earned a retirement benefit due to their career of service.

I believe any framework for reform needs to begin with an assessment of what is working and not working, what the environmental conditions are likely to look like in the future, including the 'go to war' capabilities and needs, and what approach will likely ensure success in the future.

For my nearly 20 years of privileged service at the side of DOD and now VA [Veterans Affairs], I believe there are four fundamental questions worthy of exploration.

First, does DOD have the optimal footprint and most effective, efficient management structure and tools and system to deliver on the needs? Is the investment in the direct care system being optimized? There is a great deal of expense inherent in the physical footprint, the equipment that has to be purchased and kept current

and the personnel required to effectively staff the footprint. There is great efficiency and effectiveness to be gained when sizing a system, when making ‘make versus buy’ decisions and collaborating appropriately, and perhaps even when leasing versus traditional ownership of plant and equipment is broached.

I also believe that telehealth and data and analytics tools and the corollary personnel investments need to be maximized, especially in this day and age.

As for management structure, there has been much written, proposed, and discussed on this topic over the years. It would seem that there is an opportunity in this space as well to achieve savings and enhance effectiveness, just as has been done with the evolution in the way in which the military medical community now supports the warfighter in theater. While not easy, streamlining the number of players and consolidating functions will also make the organization more agile and fiscally efficient.

Second, does the benefit available to the population make sense and is it priced properly?

The individual that testified just before me spoke eloquently of one component part that ought to be considered. As we all know, the TRICARE benefit has evolved greatly in the last 20 years. Having said that, one challenge that remains constant is what to do with the pricing structure which was previously addressed. I believe that part of that needs to include indexing. One of the challenges often with programs that are developed is that we fail to index them. I think a simple, actuarially based and automatic triggered index would be worthy of consideration.

Third, is access to care easy, and what is the optimal approach to providing the direct care system with the needed elasticity to ensure that access to quality providers is available to meet the needs that the direct system cannot meet itself?

My understanding is that an electronic authorization system that allows workflow to efficiently and effectively move between the direct system and the TRICARE contractors and providers still does not exist. I would say that needs to be remedied, and it needs to be grounded in processes that are effective and efficient, to include supporting how to make sure that appointments work effectively and accurately.

Lastly, I would say that the networks built by those that support the DOD as contractors need to be constructed to match the need that exists for care in the community. One size does not fit all. In order to optimize the DOD budget, those networks should be priced at market rate.

Fourth, are we optimally promoting health and effectively and efficiently supporting those whose unmanaged health issues are both bad for the individual and presenting avoidable expense to the taxpayer?

Optimally promoting health starts with effectively supporting the patient, which my colleagues have addressed previously. If done right, it also results in cost avoidance, so the two go hand in hand. Segmenting the population and focusing in on those who benefit most from assistance in the management of their conditions is just smart and annually reviewing the analysis of the population’s health is critical to doing this right.

Developing and deploying an integrated approach to disease management for that specific profile of conditions is also critical, something that we tried in TRICARE when I was doing it and we failed to focus in on the right spaces where opportunity exists. You want the treatment to be coordinated and well managed, regardless of where the care is delivered, whether it is in the direct system or in the community.

There should then be the development of a customized treatment plan for the individual patient and the modification of the design of the TRICARE program to provide a series of incentives and disincentives for compliance with that treatment plan.

Lastly, provider payment models that appropriately reward providers for quality outcomes and reduce an overall spend need to be adopted as they are the key partner in delivering care. I would suggest doing pilots to continue to test this, but then deploying it effectively and quickly is important.

Senator Gillibrand, I would like to draw your attention to one prototype that I was privileged to be a part of with one of the next panel's participants. That is at the side of the first lady then of the Marine Corps, Annette Conway, who was a special educator. We had the privilege, then-Captain Faison and myself, now the Navy Surgeon General, to prototype how to put a special needs program together to serve the families at Camp Pendleton. I believe, sir, that that worked extremely effectively. There are some clues there from a while ago, and there are probably clues from current pilots that could be rolled out and made available as you map the final policy.

In closing, I want to thank you for the invitation to appear before you today. It was an honor and a privilege for my colleagues and I at TriWest Healthcare Alliance and our nonprofit owners to be of service to the beneficiaries of the military health system at the side of the ladies and gentlemen who wear the cloth of the Nation. That is work we will not return to because we have the awesome privilege now of leaning forward at the side of the VA in the current furnace, and that is where we will stay focused until our job is done.

I hope that my testimony today has been helpful to you as you contemplate the way ahead as it relates to continuing to refine the military health system and the important TRICARE benefit. I look forward to answering any questions you might have. Thank you.

[The prepared statement of Mr. McIntyre follows:]

PREPARED STATEMENT BY MR. DAVID J. MCINTYRE, JR.

INTRODUCTION

Good afternoon Chairman Graham, Ranking Member Gillibrand, and members of this distinguished Committee.

Thank you for the invitation to appear before you today at this initial hearing on Defense Health Care Reform. I applaud you and your colleagues for taking on this subject and I am pleased to share with you my views on this topic, as you and the Defense Department seek to ensure that the Defense Health System remains strong and is able to provide optimal support to those who wear the cloth of the nation, their families and those who earned a retirement health benefit due to their career of service in the uniformed services.

For almost 20 years I have had the distinct privilege of co-founding and leading a company, TriWest Healthcare Alliance, whose sole mission is standing alongside the federal government—initially with the Department of Defense and now with the

Department of Veterans Affairs (VA)—in serving the health care needs of those who serve this country in uniform and their families. Prior to this privileged work, I had the honor of serving almost nine years in the offices of the U.S. Senate, where I was responsible for health-policy issues for the Chairman of this Committee, Senator John McCain, and Senator Slade Gorton (R-WA). That time included much engagement in this space, including at the time of the birthing of the TRICARE program legislatively.

It is with this comprehensive policy and business background that I am in front of you today. I did not go out looking to testify before you but I feel it is my personal responsibility, based on my experience in working with the federal government in this critical space and in understanding the needs of our deserving Service members and their families, that I share with you my view of how to bring best commercial practices to bear in the military health space while also maintaining the readiness of our military and ultimately ensuring the long-term fiscal health of the Department of Defense (DOD).

In 1996, a group of non-profit health plans and university health systems came together and founded TriWest Healthcare Alliance. Our initial mission was to serve the DOD in bringing up the first TRICARE contract in what were then Regions 7 and 8, which we assisted the DOD in folding into the TRICARE Central Region at a savings to the government. We then went on to serve the 21-state TRICARE West Region. While today TRICARE is recognized as a solid benefit for our nation's Service members and their eligible family members, it took many years of hard work, focus, and most importantly partnership between the contractor community and DOD's health care system to mature it to the point of stability and fashion it into the successful program that it is today. I am proud of the role TriWest played, along with our colleagues in the contractor community, in the implementation, maturation, and improvement of that program during our years of service in support of the Defense Department. After being toughened up a bit, I am even more proud today to have the privilege of bringing that same focus and singular-purpose intensity to the side of VA as they seek to enhance access to care in the community and re-set themselves for this generation's Veterans and those that will follow.

In addition, TriWest has the privilege of serving the U.S. Marine Corps as the worldwide operator of the DSTRESS stress and suicide-prevention contact center and providing back-up to their Sexual Assault Prevention and Response (SAPR) line. While certainly not perfect, I am proud to say that we have not lost a Marine in our nearly seven years of work in this critical space. We also serve the U.S. Air Force by providing appointing service in three Military Treatment Facilities in the Continental U.S.

At TriWest, we found that the successful delivery of all of these services demands a collaborative approach between all the stakeholders. I believe that history will continue to reflect positively on the road that we collectively traveled during our time at the side of DOD, as we achieved much collective success to the benefit of those that we were jointly privileged to serve. Though it took a bit of time to mature, as all large and complicated programs do, TRICARE demonstrated one of its core intended purposes in being stood up ... giving the direct care portion of the DOD Health System the ability to necessarily project forward into a theater/theaters of war and continue to provide for the needs of those staying behind given the elasticity provided through consolidated civilian provider networks. I am also very proud of the unique success we had in mapping and developing networks to Guard units across the vast expanse of our 21 states of operation, so that they and their families might have access to the basics when they were not available in their geographic locale through DOD's physical footprint.

Much of the work we did so successfully at the side of DOD has carried over to that which we are now privileged to do in support of VA as it seeks to re-tool to more successfully meet the needs of Veterans, including those of our generation's War on Terror. While that work, much like that which we were privileged to perform in support of DOD, demands our all at this moment, it was nice to have a reason to step back and reflect a bit ... and be prepared to share with you a few of my thoughts regarding the next generation of refinement/reform of the Military Health System (MHS).

Mr. Chairman and members of this distinguished Committee, I believe that any framework for reform needs to begin with an assessment of what is working and not working, what the environmental conditions are likely to look like in the future—including the “Go to War” capabilities, and what approach will likely ensure success in the future.

It goes without saying that the DOD Health System, like VA, is not the private sector ... and, parts of their mission and the expectation we all have as citizens in how we will care for and support those who put themselves in harm's way—some-

times at a very high personal cost to their health—necessarily means that it will not and should not mirror the private sector. However, there are definitely places where the private sector can ensure elasticity of access for the direct care system and bring core competencies to the equation that also afford the direct care system the ability to achieve its quality objectives and keep costs under control.

As I stepped back and thought about the reform question, based on now having the benefit of 20 amazing years of serving those who serve at the side of DOD and now VA, I would be asking four questions.

First, knowing what we know today and looking into the future, do we have the optimal footprint and most effective/efficient management structure and tools/support system? Are we effectively and efficiently optimizing the investment in the direct care system?

Second, does the benefit available to the population make sense, and is it priced properly?

Third, is access to care easy and do we have the optimal approach to provide the direct care system with needed elasticity in access to providers when they are unable to meet the health care need directly?

Fourth, are we optimally promoting health and effectively and efficiently supporting those whose unmanaged health issues are both bad for the individual and more costly to the DOD?

OPTIMAL FOOTPRINT, MANAGEMENT STRUCTURE AND TOOLS

First, knowing what we know today and looking into the future, do we have the optimal footprint and most effective/efficient management structure and tools/support system? Are we effectively and efficiently optimizing the investment in the direct care system?

There is a great deal of expense inherent in the physical footprint, the equipment that has to be purchased and kept current, and the personnel required to staff the footprint. Over the years, the DOD has had a solid focus on downsizing from hospitals to clinics where it made sense and testing various models for how to make more efficient use of operating resources. As you know, there has even been the exploration of joint use DOD/VA facilities over the years, with the most recent project in Chicago. There is great efficiency and effectiveness to be gained when sizing, make versus buy and collaboration are approached properly, and I believe it is time to look at making this approach the rule instead of the exception. I also think that evaluating leasing options versus traditional ownership is worthwhile.

I would suggest that part of optimal footprint design is the leveraging of telehealth. While DOD has made much use of this technology over the years—and certainly has been very effective in harnessing it of late to support the needs of the warfighter—I believe there would be much gained from exploring its application, and the associated tools that are starting to emerge in the marketplace, in optimizing the reach of both military and civilian providers in supporting those who use today's manpower-intensive nurse advise lines, those who suffer from chronic illnesses and those for whom behavioral health counseling would be more accessible through leveraging this mode of access.

I would also observe that all of us in health care are increasingly learning the importance of data, and data analytics capability to feed optimal decision-making ... whether it is used to determine what is made versus bought, identify the most effective targets for disease and condition management investment, or how to optimally tailor provider networks to effectively meet patient need. Solid data and the skilled people who have the ability to understand and use it must be at the core of any health reform effort. This is an area where investments are essential, and if done properly will yield much dividend down the line. Thus, I would encourage a deliberate focus on what is needed to achieve success ... in terms of the systems, the data analytics tools, and the investment in personnel needed to give the MHS [Military Health System] the critical tools needed in this area.

As for management structure, there has been much written, proposed and discussed over the years. It would seem that there is opportunity in this space as well to achieve savings and enhance effectiveness, just has been done with the evolution in the way in which the military medical community is collaborating and integrating to support the warfighter. While not easy, streamlining the number of players and consolidating functions will also make the organization more agile in the work that it does.

TRICARE BENEFIT

Second, does the benefit available to the population make sense and is it priced properly?

As we all know, the TRICARE benefit has evolved into a solid element of the compensation package for military personnel, their families and military retirees. The early days of the program were not easy as tweaks needed to be made. We all stayed at it and at the time we left our work at the side of DOD, it had evolved into one of the highest rated health plans in existence.

Having said that, one of the challenges that seem to perpetually exist is what to do with the pricing structure for the various elements of the TRICARE plan. As you and the Department work through this year's version of those decisions, I would encourage serious consideration be given to how to effectively establish an indexing approach that is simple, actuarially-based and has automatic triggers so that the need for Congress to engage in rate-setting decisions on an annual basis becomes a thing of the past.

ACCESS TO CARE

Third, is access to care easy and do we have the optimal approach to provide the direct care system with needed elasticity in access to providers when they are unable to meet the health care need directly?

One of the areas we spent a great deal of time and energy on during our work supporting the Defense Department and its TRICARE beneficiaries in the West Region was easing the complications of access to care when the supply existed within the Military Treatment Facilities. It required an elaborate and evolved set of tools and processes customized to each location to support the referrals into the facilities. When we came into the second generation of the TRICARE contracts there was to have been an electronic system which we were to connect to in order to make the process seamless. It was never built. Rather than wringing our hands, we stepped back and re-configured our approach in order to make the processes work in the absence of the electronic systems availability. My understanding is that such a system that allows for the connection between the direct care system and the TRICARE contractor seeking to ensure the maximal use of the direct care system, to the benefit of the patients and the taxpayer, still does not exist. It was a worthy notion then, and I believe that remains the case.

In working this piece, it is critical, though, that the focus not just be on electronics. It needs to start with a review of the processes for how appointments are made and managed and how authorizations move between the direct care system and the TRICARE contractors. This review should be done in order to both allow for the refinements in those processes and ultimately to ensure that the systems work for the processes they were designed to serve.

Lastly, a core element of access to care is ensuring that the networks built by the TRICARE contractors are constructed to match the need that exists for care in the community. They should provide optimal elasticity for the direct care system, which means that it is incumbent on the direct care system to be engaged in recurring Demand Capacity modeling with the TRICARE contractors. In order to optimize the budget, the networks should be priced at market rate.

OPTIMALLY PROMOTING AND PAYING FOR HEALTH

Fourth, are we optimally promoting health and are we effectively and efficiently supporting those whose unmanaged health issues are both bad for the individual and more costly to the DOD?

With infrastructure optimized, critical tools in place and fully leveraged, and access to care within the direct care system being fully leveraged with necessary and appropriate elasticity available through the provider network in the community, we are to the final piece I would like to touch on. That is optimally promoting health ... which starts with supporting the patient, and, if done right, results in cost avoidance.

It is about improving value for the patient and improving value for the taxpayer. If done right, these are not mutually exclusive concepts. Indeed, those who are doing it well in the private sector are demonstrating that both are possible. My colleagues on this panel, in fact, are very steeped in this topic.

When I look at it from my vantage point, I think there are several core elements to success.

First, it is segmenting the population and focusing in on those who benefit most from assistance in the management of their conditions. To facilitate this, I would suggest that requiring an annual analysis of the population's health by both the MHS and the TRICARE contractor would be of value.

Second, it is the development and deployment of an integrated approach to disease management for that specific profile of conditions ... so that the treatment will

be coordinated and well managed regardless of whether a specific component of care is delivered by a provider in the direct care system or a provider in the network.

Third, it is the development of a customized treatment plan for the individual patient and the modification of the TRICARE program to provide a series of incentives and disincentives for compliance with the treatment plan. The most effective programs in the country are using a mix of carrots and sticks to encourage adherence.

Fourth, is the adoption of provider payment models that appropriately reward providers for quality outcomes and reductions in overall spend as the key partner that they are in serving the patient. I would suggest doing pilots in this area to test what would work optimally in a unique system like the MHS, but I am confident that you will find significant benefit from a better alignment with the new pay tools that are emerging in the private sector and also being tested in Medicare.

CONCLUSION

In closing, I want to thank you for the invitation to appear before you today. It was an honor and privilege for my colleagues and I at TriWest Healthcare Alliance to be of service to the beneficiaries of the Military Health System as it is to now be of service to our nation's Veterans at the side of VA. I hope that my testimony today has been helpful to you as you contemplate the way ahead as it relates to continuing to refine the Military Health System and the TRICARE benefit, and I look forward to answering any questions you might have.

STATEMENT OF DR. JOHN E. WHITLEY, SENIOR FELLOW AT THE INSTITUTE FOR DEFENSE ANALYSES

Dr. WHITLEY. Mr. Chairman, members of the committee, it is a privilege to participate in this panel. The views I express are my own and should not be interpreted as reflecting any position of the Institute for Defense Analyses.

The military medical community is a dedicated force trying to provide beneficiaries a high-quality benefit and maintain their readiness to provide lifesaving care on the battlefield. This community works within a military health system that often fails to encourage these outcomes and, at times, actually hinders their ability to succeed. I commend the Congress for addressing these challenges.

I make three primary points in my written testimony, which I will summarize briefly here.

First, TRICARE reform is not simply raising beneficiary cost-shares. TRICARE reform is a chance to fix a program that has become out of step with current trends in health care. It is not simply raising costs on retirees to save DOD money. It should be able replacing a system of 5-year, winner-take-all, largely pass-through, largely fee-for-service contracts with a modernized system that improves the quality of the benefit for our families and retirees while saving the taxpayer money.

Second, TRICARE reform is an opportunity to bring an increased focus on readiness to the military health system, in particular on how to retain the capability built during the wars. As the Compensation Commission reported, quote, research reveals a long history of the military medical community needing to refocus its capabilities at the start of wars after concentrating during peacetime on beneficiary health care.

Well before the wars in Iraq and Afghanistan began, GAO [Government Accountability Office] was reporting that, "Since most military treatment facilities provide health care to Active Duty personnel and their beneficiaries and do not receive trauma patients, military medical personnel cannot maintain their combat trauma skills during peacetime by working in these facilities."

Although there were a lot of improvements made during the war, military physicians are still reporting, “Today the service that the physician was referring to has less than a dozen pre-hospital physician specialists and about the same number of trauma surgeons on Active Duty.” By comparison, that service has roughly the same number of radiation oncologists and nearly three times the number of pediatric psychiatrists and orthodontists in the force. This is largely because the medical specialty allocations are based on traditional peacetime beneficiary care needs. Refocusing on wartime needs could populate key institutional and operational billets with a critical mass of trained pre-hospital and trauma specialists and drive further advances in battlefield care during peacetime. End quote.

This focus on the beneficiary care mission brings me to my third point. TRICARE reform is also an opportunity to reform the entire military health system. The MHS is a complex, interweaving set of missions, delivery systems, benefits, and funding streams. It involves duplicative management layers and fails to incentivize unity of effort on the key system-wide outcomes of readiness, high-quality benefit delivery, and cost control.

A prime example of these MHS problems is the military hospital network. The MHS direct care system includes over 50 inpatient hospitals and over 300 outpatient clinics. The purpose of having a DOD-run hospital system is to provide the clinical skill maintenance platform for the operationally required military medical force. The day-to-day workload and operations of these hospitals are almost exclusively focused on beneficiary health care. As an example, I show in my written statement how different the inpatient workload in the direct care hospitals is from the deployed inpatient workload.

This puts military hospital commanders in an almost impossible situation, and it creates a climate of confusion within the MHS that affects everything from staffing decisions to major investment decision-making.

These military hospitals are expensive and a key driver of excess cost—of health care costs within the DOD.

Many of these incentive challenges and the mission confusion in the MHS are driven by a lack of transparency in funding. The line service leadership, the Office of the Secretary of Defense, and Congress cannot identify how much is spent on beneficiary care and how much is spent on readiness, reducing the effectiveness of resource allocation decision-making and reducing accountability.

I offer suggestions on potential reform options for each of these challenges in my written testimony, and I would very happy to elaborate on them in the question and answer period.

I would just like to close by, again, commending you for taking on these important and complex issues and for including me in this conversation.

[The prepared statement of Dr. Whitley follows:]

PREPARED STATEMENT BY DR. JOHN WHITLEY

Mr. Chairman and Members of the Committee: It is a privilege to participate in this panel. The views I express are my own, and should not be interpreted as reflecting any position of the Institute for Defense Analyses. The military medical

community is a dedicated force trying to provide beneficiaries a quality benefit and maintain their readiness to provide lifesaving care on the battlefield. This community works within a Military Health System (MHS) that often fails to encourage these outcomes and, at times, actually hinders their ability to succeed. I commend Congress for addressing these challenges and would like to make three primary points in my testimony:

1. TRICARE reform is an opportunity to improve choice and access for beneficiaries while controlling costs in DOD—it is not simply increasing cost-shares or tweaking contracts.
 - For much of the last 10 years, TRICARE reform has been defined as increasing cost-shares for beneficiaries to reduce utilization and raise revenue—saving DOD money.
 - TRICARE is a flawed program that is out of step with healthcare trends.
 - It is focused on purchasing procedures, with few tools to promote health outcomes, manage utilization, coordinate care, or control costs.
 - Pass through (government bears risk) contracting fails to incentivize contractors to manage care and improve health outcomes.
 - Five-year, winner-take-all contracts are cumbersome, uncompetitive, and hinder the infusion of new ideas from the private sector.
 - Result is poor beneficiary experience (e.g., poor choice/networks) at high cost.
 - Raising cost shares or tweaking the TRICARE contracts cannot fix this problem.
 - TRICARE should be based on purchasing a benefit (not procedures) for an individual with a risk-bearing contract.
 - The healthcare sector knows how to administer a health benefit to maximize outcomes while controlling cost—DOD should use this expertise, not shun it.
 - Annual (evergreen) contracts should be used to ensure timely adaption of new innovations as they are introduced in the rapidly evolving healthcare sector.
 - Contracts should shift financial risks and provide flexibility to incentivize contractors to use state of the art business practices in delivering the benefit.
 - Cost shares are only a part of this discussion; they are a tool, but only one of many.
2. TRICARE reform can be used to improve medical readiness, breaking the historic cycle of letting medical readiness atrophy when DOD returns to a peacetime focus following war.
 - A tremendous deployed medical capability was built during the wars, but the MHS does not have the needed case mix and volume of workload in military hospitals to sustain it.
 - Congress can leverage TRICARE reform to help prevent the loss of this capability.
3. TRICARE reform is an opportunity to reform the MHS—improving efficiency and incentives.
 - MHS is a complex interweaving set of missions, delivery systems, benefits, and funding.
 - It involves duplicative management layers and fails to incentivize unity of effort on the key system-wide outcomes of readiness, high-quality benefit delivery, and cost control.
 - TRICARE reform, with a readiness focus, could begin the process of transitioning the MHS into a more streamlined system incentivized to focus on outcomes.

TRICARE REFORM IS NOT SIMPLY INCREASING BENEFICIARY COST-SHARES

For much of the last 10 years, TRICARE reform has largely been defined by the Department of Defense (DOD) as increasing cost-shares for beneficiaries; this would reduce utilization of healthcare services and raise revenue, reducing the cost to

DOD of providing the healthcare benefit. As the Military Compensation and Retirement Modernization Commission (MCRMC) report pointed out, this narrative is, at best, incomplete. The TRICARE program is structurally flawed, and the result is poor performance at high cost. Its poor performance can be observed for many attributes other than cost-shares (e.g., choice and access). These limitations in the TRICARE benefit are largely driven by structural flaws in the design of the program. TRICARE reform is not simply raising beneficiary cost-shares; it is an opportunity to address these structural flaws to improve choice and access while controlling costs.

This framing of the debate is important. When TRICARE reform is defined as raising cost-shares, it creates a clear winner (DOD) and loser (beneficiaries who are paying more for the same quality of benefit). When TRICARE reform is understood to be modernizing a poorly performing program, it focuses discussion on solutions that leave many beneficiaries better off while simultaneously saving DOD money. The debate is no longer about whether to harm beneficiaries to help DOD, it is about how best to modernize the purchase and administration of healthcare to benefit everyone. Cost-shares can be an element of reform, but they are not the only element, and beneficiaries can be rewarded with better choice and access in return for higher cost-shares.

Structural Flaws in the Design of the TRICARE Program

In the late 1980s, as the Cold War was ending, DOD's limited method of purchasing healthcare was the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), used primarily for recruiters and others located far from military hospitals. By the 1990s, as large-scale post-Cold War rationalization of DOD infrastructure began, it had become clear that DOD healthcare was going to have to shift to a more integrated system with greater reliance on private sector care. The dominant method for purchasing care in the private sector was fee-for-service (FFS), in which doctors and other healthcare providers are paid for each service or procedure performed. FFS purchasing was also a simple approach for a system focused on purchasing wraparound or overflow care to augment its in-house facilities in select markets and situations in which it could not deliver all care itself. In this environment, the limited CHAMPUS system was transformed into the much larger TRICARE system, which today comprises three geographic regions that purchase community care through pass-through (i.e., no substantive risk transfer) five-year FFS contracts, one per region. The initial contracts (called T1) were built on pass-through FFS purchasing of care, but did allow some limited use of alternative methods for purchasing care, risk sharing between the government and the regional contractor, and contractor provision of ancillary services such as augmenting staff in military hospitals.

DOD is now on a third round of contracts (T3) and is currently in the process of contracting for T4. Two particular trends that have occurred since TRICARE's inception are important to highlight for understanding the structural flaws in the TRICARE program. The first is the movement away from FFS purchasing of healthcare in both the private and public sectors. The primary alternative to FFS when TRICARE was established was the staff model health maintenance organization (HMO). The two methods formed opposing poles, with various private sector insurers and other market participants ranging along the continuum between these poles. Modern healthcare no longer fits into this framework. There are very few market participants at these poles and the continuum between them has been replaced by intense competition in a wide-ranging space of alternative value-based purchasing (VBP) methods. The healthcare sector discovered that pass-through FFS contracting provided poor (and sometimes perverse) incentives for utilization management, care coordination, and promotion of health outcomes—in short, it was not a sustainable business model. FFS purchasing remains an element of an overall strategy for purchasing healthcare, but its use as the only method in a non-risk-bearing contract with a contractor has greatly diminished. FFS coupled with no risk transfer to the contractor is a poor program design. In the public sector, the traditional FFS Medicare (of which TRICARE is a variant) has already seen one-third of beneficiaries migrate to Medicare Advantage (risk-based plans) and the Administration has set targets to have 30 percent of individual Medicare payments made through alternative (non-FFS) methods by 2016 and 50 percent by 2018. The second important trend is that, although TRICARE started out with contracts that promoted a broader focus than just pass-through FFS purchasing of healthcare, over three generations of contracts TRICARE devolved to just that. While the healthcare sector has moved away from that model, TRICARE has narrowed to little else.

This history helps identify some of the key flaws in the design of the TRICARE program:

1. *TRICARE contracting is based on pass-through (non-risk bearing) contracting for procedures instead of purchasing a benefit for an individual with a risk-bearing contract:* TRICARE should not be built on the purchase of individual procedures or visits; it should be built on the purchase of a benefit for the individual or family. This is essential for ensuring that care is coordinated, utilization is managed, and health outcomes are promoted—the key outcomes of interest. In addition, the purchase of this benefit must transfer risk to the contractor. The healthcare sector is rapidly evolving, and a focus of a reformed TRICARE should be on the incentives being provided to the contractors to adopt and further innovate in their use of these VBP tools to promote the key outcomes of interest. Insurance carriers focus on these problems every day and are professional managers of healthcare. DOD should leverage their expertise and put it to work on behalf of military beneficiaries.
2. *TRICARE cost control strategies are based on costs per procedures instead of the total cost for the value received:* One unfortunate impact of pass-through FFS contracting is that it focuses attention on per-procedure costs while distracting attention from, and providing few tools to manage, utilization and total cost. DOD's system is anchored in its use of Medicare reimbursement rates for procedures, and TRICARE often contracts for procedures at 20 percent or more below commercial rates. This has become an overriding focus in DOD and a primary measure by which reform alternatives are evaluated (i.e., a key evaluation criterion is often whether it raises per-procedure rates). FFS models, however, incentivize increased utilization that may not be clinically necessary, and in DOD, utilization rates are 30–40 percent higher than demographically similar comparison groups. Despite paying less per procedure, DOD pays more in total per beneficiary.
 The healthcare sector is focused on total cost and the value received for the amount paid. To take a common example (taken specifically from interviews conducted in Alexandria, Louisiana), a particular market may have several orthopedic surgeons performing total knee replacements. The best surgeons may charge higher rates for the surgery (there is higher demand for their services) but may also have lower costs for the entire episode of care (driven by lower failure rates, quicker healing rates, shorter physical therapy requirements, etc.). Private insurers will observe this difference and be willing to pay the higher surgical rate, incentivizing their patients to use the more expensive surgeons. This cannot be done in the TRICARE system; regardless of health outcomes and total cost, the surgeons with the lowest per-procedure cost will be the only ones allowed. The focus on procedure rates drives other perverse results as well, e.g., narrow networks and poor access.
3. *TRICARE contracts are long-lived and winner-take-all instead of competitive evergreen contracts:* TRICARE uses winner-take-all (one successful contractor per region) five-year (often extended) contracts. The process by which TRICARE's contracts are awarded is complicated, prolonged, and characterized by protests and delays, increasing TRICARE's costs. More importantly, the lack of competition and multi-year duration of contracts limits TRICARE's ability to innovate and keep pace with healthcare trends and advances. Most other public sector healthcare programs use competitive, annual (sometimes known as evergreen) contracts, e.g., Medicare Part C, Medicare Part D, and Federal Employees Health Benefits Program (FEHBP). Large, multi-year, winner-take-all contracts can appear simple at first and may be attractive for this reason, but TRICARE experience demonstrates otherwise.

These challenges are fundamental to the design of the current TRICARE program. Minor tweaks of the program such as retaining the five-year, winner-take-all pass through structure but directing VBP instead of FFS purchasing will not substantively change the result. Each of the structural flaws should be addressed as part of TRICARE reform and the flaws are interconnected—fixing one element without the others can leave the program performing just as poorly as it currently does.

Implications of TRICARE Program Flaws

The structural flaws of the TRICARE program design cause poor performance in many areas. From the perspective of healthcare experience to the beneficiary, the flaws cause limitations on choice and access. From the perspective of DOD and the taxpayer, the flaws cause unnecessary overutilization and high costs.

The most important attribute to beneficiaries in benefit design is choice. Families and individuals in different stages of life (e.g., child-bearing years versus retirement years) and with different situations (e.g., higher income versus lower income, mar-

ried versus single, and healthy versus infirm) have different healthcare wants and needs. Providing choice among a variety of plan options allows beneficiaries to select the plan that best suits their needs, trade off added benefits against the associated premium increases, and take ownership of their healthcare experience. In a study on employer-sponsored insurance, it was found that the value placed on choice by beneficiaries equated to 16 percent of their employer-provided healthcare subsidies.¹ Choice is the most important attribute because it is the one that empowers beneficiaries to correct deficiencies in other attributes—with choice, the beneficiary can simply walk away from the plan (or provider) that isn't meeting their expectations and choose another.

Providing choice among plans also has significant value in program design and management. It corrects the winner-take-all structural flaw identified above. Under a centrally directed program design (a uniform benefit), the central authority (DOD, in accordance with statutory direction, in the case of TRICARE) designs the healthcare plan and dictates its terms to beneficiaries. Under a program designed around beneficiary choice among multiple plans, competition between the plans is created. To survive in the marketplace, contractors/carriers have to attract beneficiaries to their plan (and away from competing plans). This means that the plans have to focus carefully on designing options that are attractive to beneficiaries and provide the services beneficiaries want. It also means that they have to be price competitive, so they have to offer those desired services as cheaply as possible. Instead of having a central authority dictate to beneficiaries regardless of their preferences, a program design based on choice harnesses beneficiary preferences to improve program performance. The Office of Personnel Management (OPM) stated to the MCRMC that this competition among plans drove a one percent reduction in premium growth in the FEHBP compared to similar employer sponsor premium growth in recent years. TRICARE has experienced average cost growth several percentage points above civilian healthcare.

For most DOD beneficiaries, there are two health plan options: TRICARE Prime and the combined TRICARE Extra (network) and Standard (non-network) plan. To understand choices available to other beneficiary groups, one simple comparison group is federal civilians. Table 1 compares the plan choices available to military beneficiaries in three markets compared to the choices available to the federal civilian workforce in those markets.

Table 1.—Plan Choices for Military Beneficiaries Compared to Federal Civilians

Market Area	Military Beneficiaries	Federal Civilians
Las Vegas, Nevada	2	19
Pensacola, Florida	2	18
Leesville, Louisiana	2	16

Another key attribute is the size of the provider network available to the beneficiary. A regular concern raised by military beneficiaries is that TRICARE has limited networks. Table 2 provides a comparison between the civilian providers available to military beneficiaries in three geographic markets compared to the networks available to federal civilians in those markets for two FEHBP plans, the Government Employees Health Association (GEHA) plan and the Blue Cross and Blue Shield (BCBS) plans. Two of these markets (Fayetteville and San Diego) have military treatment facilities (MTFs) in them that expand the pool of available providers for the subset of military beneficiaries enrolled in Prime to the MTF, but even for this subset of beneficiaries, the list of available providers is dwarfed by the plans available to federal civilians.

¹ Leemore Dafny, Kate Ho, and Mauricio Varela, "Let Them Have Choice: Gains from Shifting Away from Employer-Sponsored Health Insurance and Toward an Individual Exchange," *American Economic Journal: Economic Policy* 5, no. 1 (2013): 33, 56.

Table 2.—Provider Networks for Military Beneficiaries Compared to Federal Civilians

Market Area	Specialty	TRICARE	GEHA	BCBS
Fayetteville, NC 28310 (Fort Bragg) ...	Family Practice	64	123	148
	OB/GYN	28	86	111
	Orthopedic Surgery	19	43	163
Phoenix, AZ 85004	Family Practice	94	158	124
	OB/GYN	114	126	138
	Orthopedic Surgery	84	111	108
San Diego, CA 92136	Family Practice	111	149	149
	OB/GYN	53	93	78
	Orthopedic Surgery	90	142	130

Source: Sarah K. Burns, “Network Analysis Methodology,” Power Point presentation, March 3, 2015.

It is important to note that the “narrow networks” of the TRICARE program are different from the trend in civilian healthcare being used to control costs. The narrow network options in civilian healthcare are focused on the best value providers. The Aetna Aexcel Specialist Performance Network provides a good example. Aetna considers this its “Tier 1” network, and it is narrower than their traditional network. Beneficiaries get reduced cost shares for using providers in this network. The network is developed in accordance with Aetna’s Aexcel Performance Network Designation Measurement Methodology.² The designation process is conducted every two years for a provider and is based on four criteria: volume, clinical performance, efficiency, and network adequacy. Table 3 illustrates selected clinical performance measures used by Aetna.

Table 3.—Aetna Aexcel Clinical Selected Performance Measures

Measure	Description	Specialty Attribution
30 Day Readmission Rate— Management Physician.	This measure calculates the percentage of acute care inpatient hospitalizations followed by a subsequent acute care inpatient hospitalization within 30 days of the discharge date of the first hospitalization. This measure excludes re-admissions that would have been expected based on the clinical nature of the case.	All specialties included in Aexcel.
Adverse Event Rate/Acute Inpatient Hospitalization— Managing Physician.	This measure calculates the percentage of acute care inpatient hospitalizations that include an identified undesirable (adverse) event during the hospitalization.	All specialties included in Aexcel.
Adverse Event Rate—Outpatient Procedure.	This measure calculates, for members having selected outpatient procedures, the frequency of an adverse event within the 30 days after the procedure.	Gastroenterology, Obstetrics/Gynecology, Orthopedics, Otolaryngology, Plastic Surgery, Surgery, Urology
Asthma: Use of Appropriate Medication.	This measure calculates the percentage of members age 5 to 64 who were identified as having persistent asthma and receiving appropriately prescribed medication.	Otolaryngology

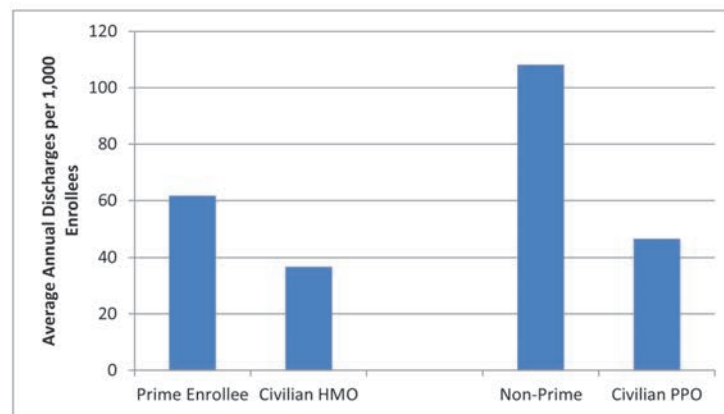
In contrast, the TRICARE network is based almost exclusively on per-procedure cost. TRICARE is a strictly FFS program design that bases its procedure rates on Medicare procedure pricing. A major determinant of network designation for TRICARE is the willingness of the provider to accept a procedure rate below Medicare rates. In other words, the TRICARE network is limited to those providers in a market willing to take the lowest rates for their services. Although basic standards of licensure and credentialing are maintained, there is little room for consideration of health outcomes similar to that described in Table 3 for Aetna’s Aexcel program.

² Aetna Performance Network Designation Measurement Methodology, 2016.

This creates a contrast between Aetna's definition of a narrow network option and TRICARE's narrow networks. Aetna's narrow network is built upon the providers offering the best value, whereas TRICARE's narrow network is based on the providers that accept the lowest rate. This difference in perspective is driven by the fact that the healthcare sector is focused on total cost and the value received for the amount paid. An example of this was provided above about an orthopedic surgeon in Alexandria, Louisiana. That market has several orthopedic surgeons performing total knee replacements. The surgeon widely-regarded as the best surgeon in the area can charge higher rates for the surgery (there is higher demand for their services), but generally experiences lower costs for the entire episode of care (because of lower failure rates, quicker healing rates, shorter physical therapy requirements, etc.). Private insurers observe this difference and are willing to pay the higher surgical rate, incentivizing their patients to use the more expensive surgeon. This cannot be done in the TRICARE system; regardless of health outcomes and total cost, the surgeons with the lowest per procedure cost will be the only ones allowed in the TRICARE network. The surgeon discussed in Alexandria was not a TRICARE network orthopedic surgeon.

It is also important to note that this is not a criticism of the TRICARE contractors. They are presumably doing the best job they can, given the contracts awarded to them and the constraints of the system within which they operate. In fact, the incumbent contractors have experience outside of TRICARE, where they are making great strides in raising quality while controlling costs—but they are prohibited from applying those innovations to TRICARE.

From the perspective of DOD and the taxpayer, the problems created by the flawed design of the TRICARE program include high utilization and cost. Healthcare utilization necessary for good health outcomes is a good thing, but the TRICARE program design encourages utilization for which the benefits do not exceed the costs. One simple comparison is to use DOD's data on utilization rates for inpatient care for military beneficiaries compared to the utilization for a demographically similar group of people in civilian healthcare plans. This comparison can be made for beneficiaries in TRICARE Prime with a comparison group in civilian HMO plans and, separately, beneficiaries in TRICARE Standard and Extra with a comparison group in civilian Preferred Provider Organization (PPO) plans. Figure 1 provides these comparisons for 2014, showing that, for Prime enrollees, utilization is 68 percent higher than the comparison group and, for Standard and Extra users, utilization is 133 percent higher than the comparison group.³

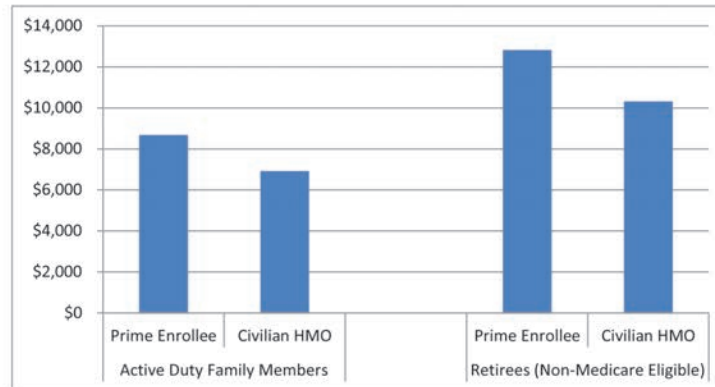


Source: 2015 TRICARE Evaluation Report, pp. 78 and 79.

Figure 1. 2014 Utilization Comparison for Inpatient Care

³For outpatient utilization, Prime enrollees had more encounters than their demographic equivalents in HMO plans, while Standard and Extra users had fewer encounters than their demographic equivalents in PPO plans.

For cost, one simple exercise is to compare DOD's data on the cost of healthcare utilization for TRICARE beneficiaries to the utilization for a demographically similar group of people in civilian health care plans. Figure 2 provides this comparison for Active Duty family members and, separately, for non-Medicare eligible retirees. The comparison is for Prime enrollees compared to a demographically similar group enrolled in a civilian HMO (Health Maintenance Organization) plan.⁴



Source: 2015 TRICARE Evaluation Report, p. 95.

Figure 2. 2014 Cost per Family Comparison

The lower cost shares of the TRICARE program (primarily in TRICARE Prime) are only one factor driving these differences in utilization and cost. The nature of the TRICARE contracts incentivizes increased utilization—the lack of risk transfer along with the lack of flexibility provided to the contractors means that they have little incentive or ability to manage utilization for cost control. In testimony to the MCRMC, Dr. Gail Wilensky provided cost estimates of the potential savings from TRICARE reform, and only about half of the estimated savings was from changes to cost shares; the rest was from non-cost-share improvements to program design.⁵

Some Basic Principles for TRICARE Reform

The healthcare sector is adopting VBP (Value-Based Purchasing) methods to promote health outcomes, improve utilization management, better coordinate care, and control cost. TRICARE reform should be informed by these trends but, as stated above, simply directing VBP within the existing TRICARE program structure is not modernization of the program.

Every transaction is different and a clean and definitive taxonomy of VBP methods has not yet emerged. Some of the more common examples include:

1. *Capitation*: Imposing risk (partial or full) on delivery system to incentivize improved management of the provider and greater coordination of care.
2. *Bundling*: A set of providers agreeing to collectively accept a pre-determined payment equal to the expected cost for a given set of healthcare services.
3. *Accountable Care Organizations (ACOs)*: Integration of providers to achieve joint accountability for achieving quality improvements and reductions in the rate of spending growth.
4. *Pay-for-Performance*: Linking payment to measures of quality and care.

My fellow panelists are experts in these trends and will likely speak in much more detail about them.

These VBP purchasing trends are primarily focused on the market between the contractor and the delivery system. DOD's direct influence is on the transactions between the employer (DOD) and the contractor. This is where DOD has the oppor-

⁴Results are similar for Active Duty family members who are Standard and Extra users. Retirees who are Standard and Extra users show a smaller difference in cost.

⁵Gail Wilensky, "Alternative Strategies to Influence Cost and Utilization," PowerPoint presentation, April 9, 2014.

tunity to incentivize efficient purchasing practices. Figure 3 illustrates the structure of the market within which the TRICARE contracts operate. As stated above, the market between DOD and the contractor is currently composed of five-year, winner-take-all contracts with little substantive risk-bearing by the contractor, and largely restricts the contractor to FFS purchasing methods in the downstream market between the contractor and the delivery system.

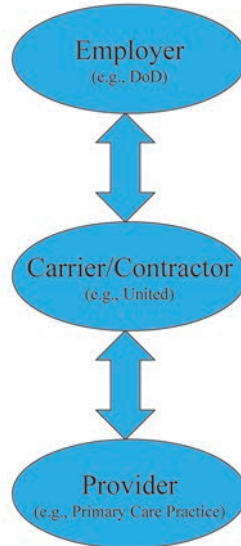


Figure 3. Healthcare Markets and Contracting Environment

Three basic principles for the design of the TRICARE program in the relationship between DOD and the contractor that will determine how well the program will ultimately perform are:

- *Competitiveness*: This is a key to incentivizing carriers/contractors to focus on the preferences of beneficiaries.
- *Risk-bearing*: This is a key to incentivizing the carriers/contractors to aggressively manage cost and improve outcomes.
- *Flexibility*: This allows the risk-bearing carrier/contractor to compete and evolve their suite of tools as the market changes and conditions vary across markets.

As discussed above, choice is the key attribute of benefit design because it empowers the beneficiary to correct other problems with the benefit, and it creates a simpler program design that is self-correcting and monitoring—a plan that fails to offer what the beneficiaries want is driven from the market, with no DOD intervention required. The ultimate objective of TRICARE reform should be to ensure that beneficiaries have multiple options in each market from which they can choose. Most large federal healthcare programs are based on this principle (e.g., Medicare Part C, Medicare Part D, and FEHBP). These existing government programs provide examples of how TRICARE reform could accomplish this. Per the MCRMC recommendation, TRICARE reform could provide a cafeteria-style menu of plan options in each market (similar to FEHBP). The MCRMC recommended moving at once to this alternative to avoid paying overhead for two distinct program designs and for improved incentives, but an alternative would be to make FEHBP enrollment an option for beneficiaries in select markets to begin a process of transitioning to a competitive framework. Alternatively, the Medicare Part C approach could be used and, in fact, is already used in six areas of the country with the United States Family Health Plan (USFHP), although this is the only allowed alternative in these markets, which does not allow for full competition. In this framework, TRICARE reform could include the expansion of additional fully capitated (i.e., risk-bearing) plans in

individual markets. These additional plans could be delivery system-based like USFHP or could be expanded to allow traditional insurance carriers to provide options within markets. Like Medicare Part C and USFHP, specific plan attributes could be regulated (e.g., covered services and cost-share structures).

Risk-bearing contracting incentivizes the contractor to focus on cost. In traditional contracting, forcing the contractor to bear risk raises cost, and self-insuring (DOD bearing the risk) lowers average cost. That logic applies when all else is held constant. In healthcare contracting, the biggest factors in determining the contractor's costs are the incentives placed on them to manage care and control cost. In other words, exposing the contractor to risk can actually lower the cost of delivering the benefit.

With competitive, risk-bearing contracts, the contractor can then be given the flexibility (in both VBP methods and, within established bounds, in benefit design) to deliver the benefit. In the current TRICARE design, DOD's strategy for ensuring contractor performance is to micromanage the contractor (e.g., directing them to use FFS contracting only). With competitive, risk-bearing contracts, the choice behavior of beneficiaries ensures contract performance, and the contractors can be left free to innovate and adapt to market conditions as they vary geographically and evolve over time.

Different reform options (e.g., making FEHBP available or adding capitated plans in each market) can be evaluated based on the degree to which they advance these principles. The more the three principles are advanced, the higher the quality of the benefit will be and the greater the savings to DOD. Figure 4 illustrates how these different reform options can be evaluated.

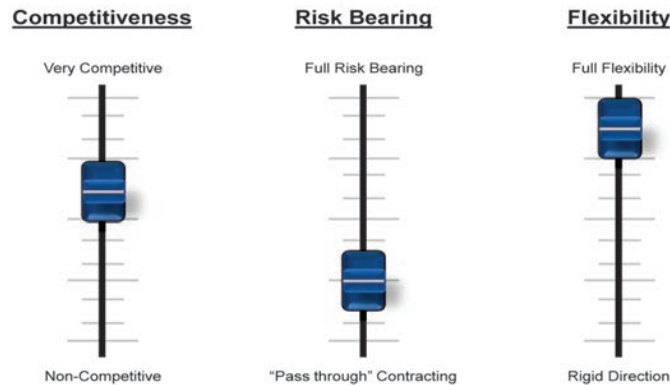


Figure 4. Three Elements of TRICARE Reform

Although they are not the primary focus of this testimony, it is also important to briefly mention two additional populations of TRICARE beneficiaries: Reserve Component members and Medicare-eligible retirees. Members of the Guard and Reserve eligible for TRICARE benefits experience many of the same challenges with choice and access as Active Duty family members and retirees, but the impact of TRICARE's design flaws can be even more severe. Many Guard and Reserve members live further from military bases than the Active and retiree populations, where TRICARE networks can be even less developed, driving even more significant choice and access problems. TRICARE reform is an opportunity to improve the health benefit provided to Guard and Reserve members.

Medicare-eligible retirees using the TRICARE for Life (TFL) program present a unique opportunity for TRICARE reform if Congress decides to include that population. TFL beneficiaries' healthcare costs are paid both by Medicare and DOD. Their costs tend to be very high and, for similar reasons to the discussion above, there is little coordination of their care for promotion of health outcomes and cost control. This is even more important for this older population because of the higher complexity of their care as they age. Neither DOD nor Medicare are fully in control of this situation or incentivized to deal with the problem because of the division of the costs. Significant opportunities are likely available to improve care while reduc-

ing costs by introducing capitated (e.g., Medicare Advantage-like) plans for Medicare-eligible retirees.

TRICARE REFORM CAN BE USED TO IMPROVE MEDICAL READINESS

The readiness of the military medical force to conduct its deployed mission should be a primary consideration in TRICARE reform. The military medical community built an incredible level of capability and readiness during the wars in Iraq and Afghanistan. The MHS in its current form cannot maintain that capability, and it will atrophy as attention returns to peacetime beneficiary care delivery. The MCRMC found that “[r]esearch reveals a long history of the military medical community needing to refocus its capabilities at the start of wars, after concentrating during peacetime on beneficiary health care.”⁶ TRICARE reform should be leveraged to break this historic cycle and help ensure we start the next war with the most ready medical force possible.

Medical readiness challenges

The military medical mission of DOD is to provide a medical force ready to deploy for the provision of medical care. The MHS combines this operational mission with the delivery of beneficiary healthcare by using the military medical force during peacetime to deliver a portion of beneficiary healthcare in house in military hospitals. Although there have been long standing challenges with this model,⁷ it arose in a period of time when medicine was less specialized than today and theater medical care included significantly longer-term care than is currently practiced.

The challenges with the model have grown over time as there have been changes to warfighting and the practice of medicine. Examples of these changes include:⁸

- Moving to a more decentralized, mobile battlefield—which drives a smaller medical footprint in operational theaters;
- Evacuating casualties early—which is better for the casualties and reduces risk to forces in theater;
- Greater specialization in the profession of medicine; and
- Shifts in medical workload on the modern battlefield, e.g., more immediate and less definitive care, different wound and injury patterns as body armor and weapons evolve, and earlier transportation of patients than would have occurred in earlier conflicts.

These changes in warfighting have implications for medical force requirements and readiness. The shift to more mobile operational forces with a lighter theater footprint produced a shift in the required operational medical capabilities—medical forces may be often forward-deployed with operational units and provide more immediate complex medical care. There is also less definitive care, as the historic model of extensive in-theater care, practiced in World War II and Korea, has been replaced with rapid evacuation to hospitals outside the operational theater. Lower in-theater holding times decrease the deployable medical requirement. However, a lower theater medical requirement that is deployed further forward and provides more immediate care limits the opportunities for substitution across specialties, increasing demand for highly specialized medical personnel. A hospital with a requirement for ten surgeons can more readily substitute two obstetricians alongside eight surgeons than a forward-deployed surgical team with a requirement for two surgeons; there is not enough overlap in staff for the requirement to be met with one surgeon and one obstetrician. In summary, the degree of overlap between the operational mission and the beneficiary care mission has eroded over time, causing the readiness requirement to become increasingly focused on more complex immediate life-saving care that is seldom seen in peacetime military hospitals.

As the MCRMC report identified, “[r]elying on existing MTF medical cases as a training platform for combat care can result in a misalignment of military medical personnel compared to the medical requirements necessary to support the operational missions.”⁹ Table 4 illustrates this misalignment in the early years of Operation Iraqi Freedom and Operation Enduring Freedom. The Service-identified medical force requirements were for operationally required specialties such as surgeons

⁶MCRMC report, citing Bernard Rostker, *Providing for the Casualties of War: The American Experience Through World War II* (Santa Monica, CA: RAND, 2013) and General Accounting Office, *Medical Readiness: Efforts Are Underway for DOD Training in Civilian Trauma Centers*, GAO/NSIAD-98-75 (Washington, DC: GAO, April 1998), 12.

⁷Rostker, *Providing for the Casualties of War*.

⁸This material is drawn from John E. Whitley, Brandon Gould, Nancy Huff, and Linda Wu, “Medical Total Force Management,” IDA Paper P-5047 (Alexandria, VA: Institute for Defense Analyses, May 2014). See that paper for a more detailed discussion.

⁹MCRMC *Final Report*, 64–65.

and anesthesiologists, but the actual executed force was composed of specialties more in demand for beneficiary healthcare.

Table 4.—Misalignment of Medical Force

Specialty	FY 2004 Military Requirement	FY 2004 Executed End-Strength	End-Strength Minus Requirement
Pediatrics	286	645	359
Obstetrics	208	387	179
Anesthesiology	318	259	-59
General Surgery	685	443	-242

Source: "DOD Force Health Protection and Readiness—A Summary of the Medical Readiness Review, 2004–2007," June 2008.

Although this misalignment improved during the wars,¹⁰ more recent research has still found misalignment:

Today the U.S. Army has less than a dozen prehospital physician specialists and about the same number of trauma surgeons on Active Duty. By comparison, the Army has roughly the same number of radiation oncologists and nearly three times the number of pediatric psychiatrists and orthodontists. This is largely because medical specialty allocations are based on traditional peacetime beneficiary care needs. Refocusing on the wartime needs could populate key institutional and operational billets with a critical mass of trained prehospital and trauma specialists and drive further advances in battlefield care during peacetime.¹¹

These alignment issues are a significant readiness challenge. During the wars, the medical force experienced uneven deployment rates, with the operationally required specialties having relatively high deployment rates and experiencing potential force stress while other specialties hardly deployed.¹² Interviews conducted with Combatant Command (COCOM) staffs by the MCRMC found challenges in sourcing operational medical requirements.

The reason for this misalignment is that the military hospital system does not have sufficient workload to support the operationally required specialties—so the military medical force migrates to beneficiary care specialties. The challenge is compounded by the fact that even when the right specialties are employed, the workload is still not ideal for preparing the medical personnel for their deployed mission. As the MCRMC report identified,

[s]urgeons overwhelmingly cited vascular surgeries as the most difficult cases [they faced in combat], followed by neurosurgical procedures, burns, and thoracic cases. Surgeons reported they had difficulty with these procedures because they had not performed them in nondeployed clinical settings, and because there had been a substantial time lapse since they had last treated these types of injuries.¹³

GAO found "[s]ince most military treatment facilities provide health care to Active Duty personnel and their beneficiaries and do not receive trauma patients, military medical personnel cannot maintain combat trauma skills during peacetime by working in these facilities."¹⁴

To illustrate this challenge, Table 5 provides the top ten inpatient diagnoses in the military hospital system in 2015 and Table 6 provides the top ten inpatient diagnoses in Iraq in 2007.

¹⁰ John E. Whitley et al., "Medical Total Force Management."

¹¹ R. L. Mabry and R. DeLorenzo, "Challenges to Improving Combat Casualty Survival on the Battlefield," *Military Medicine* 179, No. 5 (May 2014): 477–82.

¹² Whitley et al., "Medical Total Force Management."

¹³ MCRMC *Final Report*, 63–64, citing Joshua A. Tyler et al., "Combat Readiness for the Modern Military Surgeon: Data from a Decade of Combat Operations," *Journal of Trauma and Acute Care Surgery* 73, No. 2 (2012): S64–S70, <http://www.ncbi.nlm.nih.gov/pubmed/22847097>.

¹⁴ General Accounting Office, "Medical Readiness: Efforts Are Underway," 12.

Table 5.—Top Ten Inpatient Diagnoses in Military Hospitals, 2015

Clinical Classification Software (CCS) Grouping	Dispositions
Newborn Care	48,490
Normal Pregnancy and Delivery	46,947
Complications of Pregnancy	45,427
Unclassified Care	44,281
High Blood Pressure	43,701
Perinatal Conditions	37,695
Screening/History of Mental Health and Substance Abuse	36,403
Complications of Pregnancy—Care of Mother	32,708
Disorders of Lipid Metabolism	31,305
Nutritional, Endocrine, and Metabolic Disorders	27,887

Table 6.—Top Ten Inpatient Diagnoses in Iraq, 2007

Clinical Classification Software (CCS) Grouping	Dispositions
Open wounds of head, neck, and trunk	3,488
Open wounds of extremities	2,650
Other injuries and conditions due to external causes	2,274
Fracture of lower limb	992
Nonspecific chest pain	986
Abdominal pain	683
Crushing injury or internal injury	589
Other specified and classifiable external causes of injury	571
Fracture of upper limb	563
Skin and subcutaneous tissue infections	543

These tables understate the challenge because, in addition to having different preponderances of diagnoses, even when the diagnoses overlap, they differ in their severity. For example, open wounds of the head, neck, and trunk are seen in military hospitals, but the cases seen in Iraq were over twice as severe (as measured by probability of death) as those seen in military hospitals. For open wounds of extremities, the Iraq cases were almost four times as severe as the military hospital cases.

Leveraging TRICARE reform to improve medical readiness

The MCRMC recommended a comprehensive solution to deal with these challenges that included:

- Providing new tools and access to new beneficiary populations to attract a medical workload of the required case mix and complexity to maintain medical readiness;
- Developing a new concept of “Essential Medical Capabilities” (EMCs) and integrating EMCs into readiness reporting tools and processes to increase measurement, transparency, and accountability for medical readiness;
- Realigning funding to improve incentives for maintaining medical readiness; and
- Establishment of new command structures and changes to Joint Staff structures to focus leadership attention on medical readiness and provide authority to ensure it is a priority.

The third element of the recommendation (realigning funding) will be discussed in the final section of this testimony under MHS reform. The fourth element of the recommendation (new command structures) is beyond the scope of this testimony on TRICARE reform (although streamlining management structures is mentioned in the final section on MHS reform). The first two tie integrally into TRICARE reform.

The first element (new tools and populations) is directly relevant to TRICARE reform. In its simplest form, there are only two solutions to the readiness problem—patients providing the right case mix have to be brought to the military medical personnel for training or the military medical personnel have to be taken to the right patients. Our allies have wrestled with this problem already. The United Kingdom closed its military hospitals and moved its military personnel to civilian hospitals with more volume and better case mix. Germany still has military hospitals but has opened them to civilian patients. We are big enough to follow an “all of the above” approach. TRICARE reform provides an opportunity to begin this transformation.

DOD currently has few tools for attracting care into MTFs. Compounding this problem is that the few tools available, e.g., cancelling civilian primary care managers, brings the wrong care into MTFs—it brings routine and primary care into MTFs when what is needed is a case mix that includes complex surgery and trauma. Redesigned TRICARE contracts can include provisions to channel certain types of care into MTFs. The most rigorous example of this is provided by the MCRMC recommendation that the MTFs be reimbursed for the care they deliver and allowed to differ the prices of procedures to attract the right case mix. Although using price is the most powerful way to channel care, there are also more limited options that can be used. One straightforward method would be to include performance measures in the redesigned TRICARE contracts that include channeling of care and are tied to payments. Another would be to make the MTFs available to the contractors for free or reduced-price care for the required case mix.

TRICARE reform also provides opportunities for getting military medical personnel out to civilian settings that provide a better case mix. One direct approach would be if delivery systems become TRICARE contractors. This would increase DOD's ties to these healthcare providers and expand opportunities for placement of military personnel into civilian facilities.

The EMC recommendation of the MCRMC is focused on improving transparency and accountability for readiness. An important reason for directing DOD to implement the EMC framework as part of TRICARE reform is that it will give Congress information on readiness that can be used to evaluate readiness trends, providing Congress an opportunity to provide oversight and further direction if DOD begins to let readiness lapse during peacetime.

TRICARE REFORM IS AN OPPORTUNITY FOR MHS REFORM

The MHS is a complex interweaving of missions (beneficiary care and readiness), delivery systems (MTFs and purchased care), benefits, and funding sources. It involves duplicative management layers and fails to incentivize unity of effort on the key outcomes of maintaining readiness, providing a high-quality benefit, and controlling cost. TRICARE reform provides Congress an opportunity to reform the entire MHS to create a more streamlined system that incentivizes a focus on these outcomes.

As stated in the previous section, the MHS combines two primary missions. The operational or readiness mission—inherently military and performed with military personnel—is to provide medical care during wartime or other deployed contingencies. The MHS also supports the beneficiary care mission, which does not have to be performed with military personnel or hospitals; about two-thirds of this mission is delivered by purchasing private sector care. The reason that some of the beneficiary care mission is performed in house is because it has historically been used as the training venue for the military medical personnel supporting the operational mission. These personnel have had dual assignments; they are assigned to a military hospital to provide beneficiary healthcare in-house and are also assigned (directly in their assignment orders or indirectly by forming a pool of available personnel) to an operational platform such as a theater hospital or a surgical company. Figure 5 illustrates this dual-mission framework.

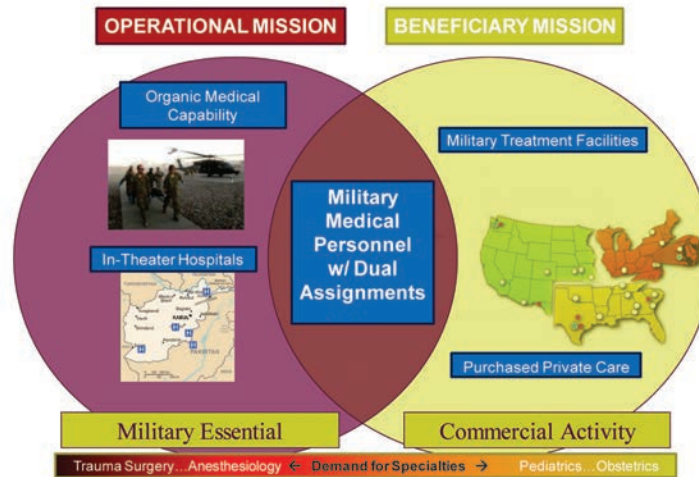


Figure 5. Dual-Mission Framework of MHS

The dual mission framework dominates the organization of the MHS. Military personnel are required for the operational mission, but used for the beneficiary care mission. MTFs are justified as readiness training platforms for the operational mission, but used for the beneficiary care mission. A large portion of the funding for both missions is provided in a consolidated appropriation (the Defense Health Program (DHP)). Leadership are responsible for both missions, but may have their evaluations dominated by beneficiary care considerations.

Specific challenges created by the structure of the MHS include:

- Conflicting missions for the military hospital system: The “direct care” system of MTFs exists to support the readiness of the military medical force, but is generally used for beneficiary healthcare with little readiness focus in its day-to-day operations.
- Lack of transparency in funding: The line Service leadership, Office of Secretary of Defense (OSD), and Congress cannot identify how much is spent on beneficiary care and how much is spent on readiness, reducing effectiveness of resource allocation decision making and accountability.
- Lack of focus on readiness (discussed in the previous section).

Conflicting Missions for the Military Hospital System

The MHS direct care system includes over 50 inpatient military hospitals and over 300 outpatient clinics. The purpose of having a DOD-run MTF system is for it to serve as the clinical skill maintenance platform for the operationally required military medical force. Its day-to-day workload and operations are almost exclusively focused on beneficiary healthcare. This puts military hospital commanders in an almost impossible situation and creates a climate of confusion within the MHS that affects everything from staffing decisions to major investment decision making. Some simple examples of the confusion include:

- Emergency Medicine: Emergency medicine physicians were one of the specialties with the highest deployment rates to Iraq and Afghanistan.¹⁵ Touring a typical MTF reveals that the Emergency Department is often staffed with contracted civilian physicians while pediatrics and obstetrics are mostly military.
- Outsourcing Surgical Workload: Surgical workload is generally more relevant for maintaining the clinical skills of the military medical force, but MTFs generally outsource this workload to private sector care while retaining in house more care in areas like obstetrics. Table 7 illustrates this for three DOD mar-

¹⁵ Whitley et al., “Medical Total Force Management.” See Figure 2, p. 32.

kets, and it can be seen that obstetric workload is generally kept in house at over twice the rate of surgical workload.

Table 7.—Surgical versus Obstetric Workload Mix

Market	Surgical Workload			Obstetric Workload		
	Military Hospital	Purchased Care	% Military	Military Hospital	Purchased Care	% Military
Las Vegas, Nevada	1,315	4,749	22%	582	651	47%
Pensacola, Florida	657	5,403	11%	368	888	29%
Ft. Polk, Louisiana	192	203	49%	409	24	94%

- Graduate Medical Education (GME) Programs: The direct care system supports DOD-run GME or residency programs, but there is little attempt to focus these on operationally required specialty areas like trauma, surgery, emergency medicine, etc.

This confusion is an important driver of excessive costs in the MHS. The direct care system is expensive to operate, with the average military hospital costing about 50 percent more to deliver inpatient care than it would cost to purchase that care in the local markets at current payment rates.¹⁶ Table 8 illustrates this cost difference for three markets in which DOD operates.¹⁷

Table 8.—Military Hospital Inpatient Costs versus Private Sector Care

Market	Inpatient Military Hospital Cost	Cost of Purchasing Care in Local Market
Nellis Air Force Base, Nevada	\$34,624,144	\$29,909,465
Naval Air Station Pensacola, Florida	\$31,180,755	\$13,747,915
Ft. Polk, Louisiana	\$14,727,029	\$6,604,439

Source: Lurie, "Comparing the Costs of Military Treatment Facilities with Private Sector Care."

When the direct care system is successfully delivering its readiness mission, i.e., providing readiness training for the military medical force, this excess cost may be justified—a necessary cost for ensuring our warfighting capability. In cases in which the direct care system is not succeeding in its mission, this excess cost is a source of inefficiency in the MHS—wasting taxpayer resources that could be used to increase compensation or reallocated elsewhere in the defense budget for mission delivery.

DOD recently conducted an extensive internal study of the direct care system, finding that many military hospitals did not have economically viable inpatient capacity and should be right-sized to the workload they can effectively support. This study, the *MHS Modernization Study*, was not able to directly assess the degree to which military hospitals were meeting the readiness mission and instead focused on workload in major specialty areas. Although imperfect, this workload analysis provided a valuable "lower bound" measure for the readiness question—a hospital that does not have enough workload in a particular specialty area to maintain an economically viable capacity does not have enough workload to maintain the readiness of military providers in that area.

The *MHS Modernization Study* also ended up providing important evidence on why the direct care system is so costly. It found very low levels of productivity across specialties and across facilities in the direct care system. The study began by obtaining civilian provider workload by specialty. It then compared DOD providers in the direct care system to these civilian distributions, finding that providers in the DOD direct care system were generally below the tenth percentile of civilian providers in workload produced per year. Table 9 provides data DOD shared with the MCRMC from the *MHS Modernization Study*. For four specialties, it provides the average workload—as measured by relative value units (RVUs), which provide a measure of intensity-adjusted workload—of providers within MTFs as a percentage of the civilian median. Since percentage of median is not a commonly used sta-

¹⁶ See Philip Lurie, "Comparing the Costs of Military Treatment Facilities with Private Sector Care," IDA P-5262 (Alexandria, VA: Institute for Defense Analyses, 2016) (forthcoming). See Table 6, p. 27.

¹⁷ Inpatient care is used for illustrative purposes. Comparisons of outpatient care yield similar results.

tistical measure of a distribution, Table 10 converts it to a percentile of civilian providers under the assumption that the civilian distribution is approximated by a gamma distribution. As can be seen, the average providers in MTFs operate at significantly lower workload levels than civilian providers.

Table 9.—Average Workload in Ten Largest DOD Markets as Percentage of Civilian Median

Market	Emergency Medicine	Family Medicine	General Surgery	Orthopedic Surgery
National Capital Area	31%	43%	18%	26%
Tidewater, Virginia	49%	36%	22%	41%
San Diego, California	60%	48%	34%	35%
Puget Sound, Washington	33%	27%	36%	43%
San Antonio, Texas	28%	54%	39%	41%
Bragg/Pope, North Carolina	21%	30%	36%	39%
Ft. Hood, Texas	47%	15%	37%	37%
Colorado Springs, Colorado	35%	39%	28%	36%
Hawaii	34%	22%	39%	41%
Jacksonville, Florida	59%	55%	41%	29%

Table 10.—Average Workload in Ten Largest DOD Markets as a Percentile of Civilian Providers

Market	Emergency Medicine	Family Medicine	General Surgery	Orthopedic Surgery
National Capital Area	1%	2%	0%	0%
Tidewater, Virginia	8%	1%	0%	3%
San Diego, California	15%	3%	2%	2%
Puget Sound, Washington	1%	0%	2%	4%
San Antonio, Texas	1%	6%	3%	3%
Bragg/Pope, North Carolina	0%	0%	2%	2%
Ft. Hood, Texas	6%	0%	2%	2%
Colorado Springs, Colorado	2%	1%	1%	2%
Hawaii	2%	0%	3%	3%
Jacksonville, Florida	15%	7%	3%	1%

Very low productivity is an important proximate cause of the high cost of the direct care system, but to understand how to reform the system, it is necessary to identify root causes for the inefficiency. Likely root causes include the following factors:

- *Direct care system run as military units:* Military hospitals are led and administered as military units and justified by their readiness mission. In actual practice they are almost exclusively focused on beneficiary healthcare delivery. This misalignment of leadership and administrative structure with actual operations and functions means that the wealth of experience in civilian healthcare at running effective and efficient hospitals is not applied to military hospitals. Professional business management of these large complex businesses is not used.
- *Military hospitals don't have to directly compete for business:* Private hospitals that cannot manage themselves effectively lose business and either get better or go bankrupt. Military hospitals are protected from this disciplining force of markets by simply being given bigger budgets to account for their inefficiency and attempts are made to coerce beneficiaries that choose to go elsewhere to return to the system.¹⁸
- *Military hospitals given a budget for inputs instead of paid for outputs:* Funding large DOD support missions that approximate commercial activities with direct appropriation for their inputs instead of on a reimbursable basis for outputs produced is a funding mechanism long ago abandoned in most other large support mission areas, e.g., logistics, financial services, and information services. Military hospitals still receive their funding according to the inputs they consume instead of the outputs they produce.
- *Military hospitals overuse military personnel for non-operational specialties:* As discussed in the readiness section above, the military medical force is overstaffed in beneficiary care areas like pediatrics and obstetrics. Military personnel are generally more costly than civilian personnel, so the use of military

¹⁸ See, for example, Amy Bushatz, "Families Forced to Give Up Civilian Health Care," June 27, 2014. <http://www.military.com/daily-news/2014/06/27/some-families-forced-to-give-up-civilian-health-care.html>

personnel not required to be in uniform for delivery of beneficiary care is inefficient and drives higher costs.

Lack of Transparency in Funding

The root causes listed above all relate, at least in part, to a lack of transparency in the funding structure of the MHS. The DHP appropriation provides almost all of the funding for beneficiary healthcare and a large portion of the funding for the readiness of the medical force in a single, undifferentiated amount. The impact of this on resource allocation decision making includes:

- Healthcare benefits and medical readiness are put into a direct tradespace with each other, competing for resources against each other. Decision makers are forced to make tradeoffs between increasing medical readiness at the expense of the health benefit or vice versa, with no direct considerations of readiness more broadly or compensation more broadly.
- Medical readiness is removed from the tradespace of other readiness functions within each Service so that the Services cannot easily create a balanced readiness plan across medical and non-medical functions.
- Healthcare benefits are removed from the tradespace of compensation instruments (e.g., base pay, special and incentive pays, retirement, and quality of life programs) so that compensation cannot be easily understood and balanced across the range of compensation instruments.

This distortion of decision making trade-off spaces is compounded by the lack of visibility and transparency available to the Service line leadership, OSD, and Congress. This reduces incentives to manage healthcare. For example, a Service Chief has little incentive to actively manage the healthcare portfolio because doing so incurs the political cost of managing a three star officer within the Service, but fails to yield a benefit because the savings are within an OSD account and unlikely to be given to the Service.

Some Basic Principles for MHS Reform

The overarching principle that should guide MHS reform is increasing transparency between and separation of the operational mission and beneficiary healthcare. Complete separation may not be obtainable (at least in the short-run), but an increased degree of separation will improve focus on readiness and allow for more rational management of the direct care system and benefit. Incremental steps in which this further separation can be achieved include reforms to funding, MTF management, and benefit administration.

One of the biggest challenges mentioned above is the commingling of funding for readiness and beneficiary healthcare. TRICARE reform provides an opportunity to advance the principle of clearly identifying the costs of the health benefit and separately budget for them in the appropriate way, i.e., in the military personnel budget account. Purchasing a benefit in a risk-bearing contract provides a clear measurement of benefit cost. In addition, the budgets for many of the overhead functions are spread across DHP accounts, and TRICARE reform would centralize them in the contracts. Placing this funding into the MILPERS appropriation account would then separate it from readiness and provide it in the appropriate location for its function, increasing transparency of the defense budget and improving incentives for compensation management within DOD.

With the health benefit costs separately identified and accounted for in the military personnel accounts, the remaining funding in the unified medical program is readiness-related (or inefficiency) and can then be placed in Service readiness accounts. In addition to increasing transparency, this removes the artificial tradespace created between medical readiness and benefits. It puts medical readiness into a tradespace with other readiness investments so that efficient decision making can occur. Basic principles of funding and budgetary account structure include:

- Costs of personnel benefits should reside in MILPERS budget accounts.
- Costs of readiness should appear in Service readiness-related budget accounts.
- MTFs and other activities replicating commercial activities should be funded according to outputs produced, not inputs consumed.
- Costs should be recognized in the budget when the obligation is incurred.

The high costs of the MTF system are a major driver of costs in delivering the healthcare benefit. Ultimately, DOD will likely have to rationalize a large number of its current facilities and focus its direct care investments on the core MTFs that can become readiness training platforms, creating truly world class capabilities in the things DOD should be focused on, such as trauma, burns, and brain injuries. TRICARE reform provides an opportunity to begin reform of the MHS in ways that

will improve incentives for more effective and efficient MTF management. Three basic principles that should be applied include:

- *MTFs should be professionally managed:* Organizing and operating MTFs like military units when the majority of the daily operations are the provision of beneficiary healthcare with little difference from civilian hospitals is inefficient. It fails to take advantage of the expertise resident in the healthcare sector at running medical facilities. A simple incremental step that could be taken as part of TRICARE reform is directing that a group of MTFs be placed under civilian management (e.g., as government owned, contractor operated (GOCO) facilities) on a trial basis. One limited example of professional management being used in the management of the direct care system already is two outpatient clinics in the national capital region and by most accounts this is considered very successful. If military hospitals are to be maintained, they should be led and operated by business professionals.
- *MTF management layers should be reduced:* The direct care system is actually four separate systems, three systems separately managed by each Military Department and one additional system (the National Capital Region) managed by the Defense Health Agency (DHA). This duplication of overhead functions is another driver of high costs. Consolidating oversight of the MTFs in conjunction with the introduction of professional management per the item above would likely reduce cost. If MTFs were managed separately from the readiness function (e.g., the MTFs are consolidated within the DHA), this would also help improve the focus on medical readiness within the Services by removing the conflicting priority they face.
- *MTFs should be funded according to outputs instead of inputs:* The MTFs are the last large support function in DOD that are still funded with a budget for inputs instead of for the outputs they produce. One way to achieve this is by placing them in a revolving fund. Another, overlapping, option would be to GOCO the MTFs with the contractor's payments based on healthcare delivered.
- *MTFs should face competition:* Competition is the ultimate disciplining force in markets, and lack of competition is a primary driver of inefficiency. Ensuring that the MTFs face competition for beneficiaries and care delivery is the most important structural reform for focusing them on improvement. It should also be noted that this does not threaten readiness. The care the MTFs are primarily delivering and that would be at risk of moving to the private sector if the MTFs failed to effectively compete is obstetrics and other areas of beneficiary care that are not readiness related. In areas where DOD has invested in developing world-class readiness capabilities (e.g., burns and orthopedic rehabilitation in San Antonio), DOD should have no trouble competing for patients.
- *MTFs that cannot succeed in their mission should be downsized or closed:* Many MTFs today are not providing sufficient workload of the required case mix to support their readiness mission. For many of these, there is no reasonable or practical way to get the right workload into the facility and, thus, the facility will not be able to succeed in its mission. These facilities should be transitioned to clinics or closed.

Finally, TRICARE reform offers an opportunity to improve benefit administration. Purchasing a benefit for an individual or family in a risk-bearing contract implies transferring many of the benefit administration functions currently conducted in-house by DOD to professionals from the private sector that perform these functions for a living. This will have the likely effect of streamlining MHS bureaucracy and lowering the costs of these administrative functions. TRICARE reform could go further and affirmatively transfer responsibility for benefit administration to the personnel management and compensation community. Providing a healthcare benefit is not an inherently military function, and evidence shows that it becomes a competitor for medical readiness when combined in the MHS. Clearly defining healthcare benefits as a compensation issue to organize and manage them as such within the DOD would be an important MHS reform.

Senator GRAHAM. Thank you all.

I will lead this off and let other members ask questions. I want to thank my colleagues for attending.

I am going to make a general statement and see if you agree with it. The battlefield medical care provided in the last 14 years has produced outcomes historic in terms of warfare. Does anybody disagree with that?

[No response.]

Senator GRAHAM. The answer is you all agree. Nod your heads. Everybody nodded their head.

Let us make sure we do not break the one thing that is working. Now, Mr. Whitley, you said that military hospitals are skewed toward basically family care and not battlefield medicine readiness. Well, how do you explain that in light of my first statement?

Dr. WHITLEY. It is a very sensitive issue and I want to be very careful in how I describe it, Senator.

You said that the survival rates on the battlefield have reached unprecedented heights, and that is true. I think that is a great testament to everybody involved in that situation.

What I would caution, though, is using that as a measure of success of the clinical currency, the clinical readiness of the medical force prior to deployment, particularly at the start of the wars in 2001 and 2002 and 2003. That measure of the overall survival rate was contributed to by many things. We fought the war differently. We organized the battlefield differently. We moved patients differently, and we had some of the best men and women in uniform providing medical care down-range that we could have ever possibly had. That measure is the cumulative effect of all those things.

I think what we are asking here when we talk about the military hospitals, we talk about the readiness of the medical force, we have get down to more specific measures that get at the question of—

Senator GRAHAM. Here is my concern. If you a uniformed doctor or nurse, you can be deployed. TRICARE network physicians are not going to be deployed. What I want to do is make sure that in trying to fix a system that I think is very much in need of repair that we do not destroy the one thing that seems to work very well. I am going to look at your reform measures, but I also want to make sure that anything we do in the military hospital systems enhances the battlefield medicine. If we need that footprint, even though it may not be the most efficient way to deliver health care, because these doctors and nurses will do something nobody else will do—they will go to the battlefield themselves, and they are going and they are going to practice in an environment where they can be shot at. Let's don't miss that boat.

Dr. Loftus and Dr. Fendrick, when you look at TRICARE for families, for the retiree community and family members and Active Duty members, how antiquated would you say it is on an A to F rating?

Dr. LOFTUS. Well, that is a difficult question.

Senator GRAHAM. That is why I asked it.

Dr. LOFTUS. Yes. I would say that I have seen aspects or observed from the outside aspects that I think do—

Senator GRAHAM. What grade would you give it overall?

Dr. LOFTUS. A grade on an antiquated basis? I would give it a B.

Senator GRAHAM. We are starting with a B.

What about you, Dr. Fendrick?

Dr. FENDRICK. I would say B-plus actually.

Senator GRAHAM. Dr. McIntyre?

Mr. MCINTYRE. I would say somewhere around a B-minus in terms of keeping up with where we need to be.

Senator GRAHAM. Dr. Whitley?

Dr. WHITLEY. I will be the odd man out. I give it a C at best.

Senator GRAHAM. What is the 30-second answer to get us to A?

Dr. LOFTUS. I think that the military health system needs to do a better job of measuring its actual performance and trying to compare itself to internal and external benchmarks and to work continuously to improve that care.

Senator GRAHAM. Dr. Fendrick?

Dr. FENDRICK. I would pay providers more for providing the services that make military members healthier. There is a very strong evidence base that backs that up and go further to make it easy for those members to do that. It is very straightforward.

Senator GRAHAM. Mr. McIntyre?

Mr. MCINTYRE. I would ensure that providers are getting paid for their performance and their quality.

Number two, I would make the patient in part responsible for their care from an incentive and disincentive perspective.

Third, I would index the benefit so that it properly keeps pace with inflation.

Fourth, I would focus on the question of alignment of the providers that are in the direct care system with the providers that are downtown both in terms of requirements but also in terms of what their focus is for the patient.

Senator GRAHAM. Dr. Whitley?

Dr. WHITLEY. I would focus with respect to the TRICARE contracts—I would focus on increasing greater competition, having annual contracts with multiple winners per location. I would focus on making those contracts risk-bearing, and I would focus on increasing the flexibility to the contractor to manage the care.

Senator GRAHAM. If you have not done so, could you provide in a three- or four-page report to the committee how you would go from C to A and B-plus to A? Be specific.

[The information referred to follows:]

Dr. WHITLEY. In the Defense Healthcare Reform hearing on February 23, 2016, Senator Graham requested from the witnesses a three or four-page report to the committee on how to reform TRICARE from a C to A grade. This response provides comments on how to grade TRICARE, why it currently gets such a low grade, and options for improving TRICARE's grade.

How to Grade TRICARE

It is relatively straight forward to identify the outcomes we want from the TRICARE program and assess its performance for these outcomes. The outcomes include choice, network size and quality, access, and healthcare quality from the beneficiary perspective; and utilization management, care coordination, and cost control from the perspective of DOD and the taxpayer. My written statement submitted for the hearing provides an assessment of TRICARE with respect to many of these outcomes and in many cases the results indicate poor program performance.

Assessment of these outcomes by themselves, however, doesn't provide insights on how to reform the program. To understand program reform, assessment must be based on key program design attributes. There are three basic attributes for the design of the TRICARE contracting relationship between DOD and the contractor that will largely determine how well the program performs:

- *Competitiveness*: How many carriers/contractors compete and have an opportunity to provide services to beneficiaries in a location. This is a key to incentivizing carriers/contractors to focus on the preferences of beneficiaries.
- *Risk-bearing*: How much financial risk do carriers/contractors bear. This is a key to incentivizing the carriers/contractors to aggressively manage cost and improve outcomes.

- **Flexibility:** How much flexibility do risk-bearing carriers/contractors have to compete and evolve their suite of tools as the market changes and conditions vary across markets.

Grading the TRICARE contracts can be accomplished by evaluating them on these three attributes.



Why TRICARE's Grade is So Low

TRICARE earns a low grade because it relies on five-year winner-take-all contracts that are largely pass through from the perspective of the contractor (administrative services only) and do not allow for or encourage value-based purchasing (VBP) of healthcare by the contractor. In other words, TRICARE gets a very low score on each of the three key attributes identified above. Some specific points of further elaboration on these program design flaws include:

1. *TRICARE contracting is based on pass-through (non-risk bearing) contracting for procedures instead of purchasing a benefit for an individual with a risk-bearing contract:* TRICARE should not be built on the purchase of individual procedures or visits; it should be built on the purchase of a benefit for the individual or family. This is essential for ensuring that care is coordinated, utilization is managed, and health outcomes are promoted—key outcomes of interest. In addition, the purchase of this benefit must transfer risk to the contractor. The healthcare sector is rapidly evolving, and a focus of a reformed TRICARE should be on the incentives being provided to the contractors to adopt and further innovate in their use of these VBP tools to promote the key outcomes of interest. Insurance carriers focus on these problems every day and are professional managers of healthcare. DOD should leverage their expertise and put it to work on behalf of military beneficiaries.
2. *TRICARE cost control strategies are based on costs per procedures instead of the total cost for the value received:* One unfortunate impact of pass-through fee-for-service (FFS) contracting is that it focuses attention on per-procedure costs while distracting attention from, and providing few tools to manage, utilization and total cost. DOD's system is anchored in its use of Medicare reimbursement rates for procedures, and TRICARE often contracts for procedures at 20 percent or more below commercial rates. This has become an overriding focus in DOD and a primary measure by which reform alternatives are evaluated (i.e., a key evaluation criterion is often whether it raises per-procedure rates). Non-risk bearing FFS models, however, can incentivize increased utilization that may not be clinically necessary, and in DOD utilization rates are 30–40 percent higher than demographically similar comparison groups. *Despite paying less per procedure, DOD pays more in total per beneficiary.*

The healthcare sector is increasing its focus on total cost and the value received for the amount paid. To take a common example (taken specifically from interviews conducted in Alexandria, Louisiana), a particular market may have sev-

eral orthopedic surgeons performing total knee replacements. The best surgeons may charge higher rates for the surgery (there is higher demand for their services) but may also have lower costs for the entire episode of care (driven by lower failure rates, quicker healing rates, shorter physical therapy requirements, etc.). Private insurers will observe this difference and be willing to pay the higher surgical rate, incentivizing their patients to use the more expensive surgeons. This cannot be done in the TRICARE system; regardless of health outcomes and total cost, the surgeons with the lowest per-procedure cost will be the only ones allowed. The focus on procedure rates drives other perverse results as well, e.g., narrow networks and poor access. Expanding DOD's focus from controlling per unit input prices to focusing on total cost and experience of care is part of a cultural change that is hard for any bureaucracy.

3. *TRICARE contracts are long-lived and winner-take-all instead of competitive evergreen contracts:* TRICARE uses winner-take-all (one successful contractor per region) five-year (often extended) contracts. The process by which TRICARE's contracts are awarded is complicated, prolonged, and characterized by protests and delays, increasing TRICARE's costs. More importantly, the lack of competition and multi-year duration of contracts limits TRICARE's ability to innovate and keep pace with healthcare trends and advances. Most other public sector healthcare programs use competitive, annual (sometimes known as evergreen) contracts, e.g., Medicare Part C, Medicare Part D, and Federal Employees Health Benefits Program (FEHBP). Large, multi-year, winner-take-all contracts can appear simple at first and may be attractive for this reason, but TRICARE experience demonstrates otherwise.

These challenges are fundamental to the design of the current TRICARE program. Minor tweaks of the program such as retaining the five-year, winner-take-all pass through structure but directing VBP instead of FFS purchasing will not substantively change the result. Each of the structural flaws should be addressed as part of TRICARE reform because the flaws are interconnected—fixing one element without the others can leave the program performing just as poorly as it currently does.

Options for Improving TRICARE's Grade

The healthcare sector is adopting VBP methods to promote health outcomes, improve utilization management, better coordinate care, and control cost. TRICARE reform should be informed by these trends but, as stated above, simply directing VBP within the existing TRICARE program structure is not modernization of the program.

Most large civilian federal healthcare programs have dealt with these issues in the past and their experience provides examples for how DOD might improve its program design and performance. Three particularly relevant examples are:

- *Medicare Part C (Medicare Advantage):* A health insurance program that serves as a substitute for "traditional" Medicare (Parts A and B). Each year, plans submit "bids" (per enrollee cost) to cover the standard Medicare Parts A and B benefits. Every plan that meets specified requirements is accepted. The bids are compared to formula benchmarks that establish the maximum amount Medicare will pay a plan in a given area. Plans with bids higher than the benchmark are permitted (enrollees pay the difference as a monthly premium). Plans that bid below the benchmark split the difference between the bid and the benchmark (government savings is one share and the other share is used to provide additional benefits or reduced costs to enrollees). The government maintains direct authority to specify the minimum benefit provided.
- *Medicare Part D (pharmacy benefit):* The pharmacy benefit in Medicare. Each year, plans submit bids to provide a pharmacy benefit meeting minimum benefit requirements. The national average of the bids is then used to develop a government subsidy amount and monthly premiums for beneficiaries.
- *Federal Employees Health Benefit Program (FEHBP):* The health benefit program for federal civilian employees. Health insurers submit their plans each year, the plans must meet minimum requirements set by the government but can vary significantly over benefits above the minimum and cost-shares. Beneficiaries choose their plan in each year's open season.

All three programs use annual contracts, have multiple winners per location, allow beneficiary choice across the multiple winners, pass financial risk to the contractor, and allow flexibility to the contractor for how to purchase and manage care. They all score significantly higher than TRICARE on competition, risk bearing, and flexibility and provide examples of how TRICARE reform can be implemented.

There are multiple ways that TRICARE reform could be implemented to improve competition, risk bearing, and flexibility. Some options achieve high levels of each attribute, while others make incremental progress but do not move TRICARE all the way to a high grade. Some have gradations within them that could be used to increase or decrease performance in a given attribute. Specific examples include:

- *TRICARE "Advantage"*: A reform similar to Medicare Part C could be introduced that allows for alternative capitated plans to be offered from which beneficiaries could choose (beneficiaries could also choose to remain in "traditional" TRICARE). This could be done in all markets, or could be introduced in pilot form in selected markets. A more limited approach would direct the incumbent contractor to offer a capitated alternative more similar to what they offer in their civilian practices, a more expansive approach would allow multiple plans to be introduced in a market that compete with each other.
- *Contractor Markets*: Each TRICARE contractor could be directed to administer the TRICARE plans, creating their own contractor-operated market places within their regions. The set of plans could be similar to today's plans (a preferred-provider network style plan and a health maintenance organization style plan) or could be expanded to include a wider range of plans. Ideally contractors would be paid on a per plan basis (risk bearing), providing improved incentives for efficient utilization management.
- *TRICARE "Choice"*: The best performance would be achieved by implementing the full MCRMC TRICARE Choice proposal (along with a premium support cost-share structure). A more limited pilot approach that would move in this direction would be to open FEHBP to TRICARE beneficiaries as an option (either in a limited number of markets as a pilot or in all markets), although this would be costly to DOD given the older population in FEHBP.

Some related issues that should be considered in designing a TRICARE reform proposal include:

- *Overhead*: TRICARE overhead costs are substantial. For example, FEHBP (which covers a population similar in size to TRICARE) is administered with approximately 100 people (which are funded from premiums). The number of personnel administering TRICARE are significantly higher (exact figures are difficult to compute but likely number in the thousands). The slower the reform is implemented, the longer these high overhead costs have to be paid. The MCRMC recommended moving at once to this alternative to avoid paying overhead for two distinct program designs and for improved incentives. Slower transitions are an option, but it must be understood that this reduces the available savings.
- *Cost-Shares*: Setting cost-shares is an important decision, but one that can be separated from TRICARE reform. In most of the options described above, cost-shares could largely be maintained at their current level or changed without effecting reform implementation. In some examples (e.g., options similar to Medicare Part C), the entire range of cost-shares can be set by policy. In other examples (e.g., the options similar to FEHBP), the premium cost-share can be easily set at any level desired (using a premium support mechanism, for example) while copayment cost shares would be determined in the market place.

Senator Gillibrand?

Senator GILLIBRAND. Thank you, Mr. Chairman, and thank you all for being here.

Our country has a shortage of mental health providers resulting in many patients receiving mental health care from their primary provider. What do you see as the solution to this problem? Mr. McIntyre, specifically how does TriWest ensure that mental health providers in its network have experience with unique needs and experience with servicemembers and their dependents, including military children? Last, does TRICARE require this type of experience?

Mr. MCINTYRE. I will start. We no longer do the work in TRICARE, which was probably partly why I am here because I do not have a conflict in that regard.

When we did that, we built out a mental health network that was mapped to the needs of the population, both those that are

close to a military installation but also those that served in the Guard and Reserve, mapped to ZIP [Zone Improvement Plan] codes where they reside.

What we currently do is relevant to that topic, and that is we are doing exactly the same thing, and we are looking at the ZIP codes as to where people live. We are looking at what the direct care system actually has in the way of footprint, which I believe is applicable to the DOD, and we are in the process of going back to something that we did at the start of the wars, and that is to train the mental health providers and the primary care providers in how do you recognize where a threat is for your patient from a mental health perspective, how do you be relevant, and where do you turn people to if they are in distress.

Senator GILLIBRAND. Others?

Dr. FENDRICK. I would just say very quickly that if we really were serious about changing our conversation from how much we spend to how well we spend, we would see a serious investment in infrastructure for mental health and also incent providers and patients to do those evidence-based services.

Senator GILLIBRAND. What infrastructure changes would you make?

Dr. FENDRICK. The problem is that most medical services that are most profitable are not producing a lot of health for the money you spend, and as long as you continue to allow a fee-for-service payment system, they will go to those services that produce lots of revenue. They have never been measured on the health that has been produced, which are points made by folks to the right and left of me. I think if we again get to this point and you say I am going to still pay a lot of money for military health care but insist that it goes to services and providers for things that are actually needed, so whether it be mental health, opioid abuse, or other types of things that are away from the standard cardiology, orthopedic surgeon, other types of things that are needed but deemed to be over-used in the system—we have enough money there. It just takes the courage to make the shifts that may be going upstream against some interests who may not want that to happen.

Dr. LOFTUS. I would add that integrating mental health care into primary care is actually important. I do not mean that mental health care is provided solely by primary care physicians, but breaking down the barriers in referral and in sharing information about patients with behavioral health problems is actually important. There are great privacy concerns about behavioral health, but when primary care physicians and others treating the same patients are not aware of those issues, we cannot bring to bear all of the power of the entire multi-specialty power that we have in front of us to the care of those mental health patients.

Dr. WHITLEY. I have nothing to add. I agree with all my colleagues. I think they said it very well.

Senator GILLIBRAND. Another major concern is the care for servicemembers' special needs dependents, which I mentioned in my opening. Military families move frequently and that means that moving to and from locations with different levels of service provision.

From your private sector experience, how do we ensure that the continuity of care for these special needs are met whenever servicemembers might be moved? Mr. McIntyre, how does TriWest handle provision of this specialized service?

Mr. MCINTYRE. I think that is a fundamental question in this space. The thing that Captain Faison and myself learned at the time—then-Captain Faison—through the lens of the Marine Corps was you need to come to understand what the needs are and you need to pay attention to them and meet them while they are in your midst, and then you need to prepare and plan for their change geographically so that as they move from place to place, you are actually thinking about not only them moving forward but the receipt of them on the other side. The same thing applies, I would say, to those that are injured and those that have mental health needs as they move within the system in the military and as they also move between the military and the VA.

The last thing I would say, if I can go back for a second to the mental health piece that you raised previously. Very few providers in this country are trained in evidence-based therapies. We have a network of 25,000 mental health providers now built across 28 States. We are in the process of looking at that issue market by market. We are doing a test in Phoenix actually this weekend. We are doing something together with the private community as well as those that serve in the Federal space.

The bottom line is it is possible to go through and do that training. The expertise of it exists in the DOD and the VA spaces. It is getting those that bring those networks to the table to narrow in on the populations that need services, how many there are, what types of EBTs [Emotional Brain Training] you need, and then make the investments to actually ensure that they are trained. We are going to be testing that in the chairman's hometown of Phoenix, Arizona starting this weekend.

Senator GRAHAM. With that, Senator McCain.

Chairman MCCAIN. Dr. Whitley, I am very interested in your recommendations, one of them, MTF management layers should be reduced. Are you talking about one service?

Dr. WHITLEY. I think there are many options to do that. One option that others have talked about is consolidating the military hospital system into the existing Defense Health Agency. Another would be a single service. I think there are many options of ways you get there, Senator.

Chairman MCCAIN. Would you do me a favor and send that to me in writing?

Dr. WHITLEY. I would be very happy to, sir.

[The information referred to follows:]

Dr. WHITLEY. In the Defense Healthcare Reform hearing on February 23, 2016, Senator McCain requested a written response on options for consolidating and improving the management of military hospitals. This response provides options for consolidating management of these hospitals, additional options for reforming the management of the hospitals, implementation considerations for military hospital reform, and an appendix that summarizes some of the current challenges with military hospitals from my written testimony submitted at the hearing.

Options for Consolidating Military Hospitals

Many of the current challenges with military hospitals discussed in the appendix (e.g., funding inputs instead of outputs and lack of competition) would be directly

addressed or would be more easily addressed with a consolidation of the military treatment facility (MTF) system. This section discusses two aspects of consolidation: the organization/management of MTFs and their funding.

The direct care system is actually four separate systems, three systems separately managed by each Military Department and one additional system (the National Capital Region) managed by the Defense Health Agency (DHA). This results in a duplication of overhead functions which increases costs and makes other reforms of MTFs more difficult. In addition, there are many geographic markets with multiple facilities (from different Services) within them and rationalizing this expensive infrastructure footprint is difficult in the current structure. A system of multi-Service market management has been established, but has not yet been able to effectively deal with this challenge. Consolidation of the organization and management of MTFs would reduce overhead, improve asset and care coordination within markets, and make other reforms easier to implement.

There is another important benefit from consolidating the direct care system. Many of the problems identified in the appendix stem from the confusion created by the inter-weaving of the readiness and benefit missions. If MTFs were combined and managed separately from the readiness function, this would help improve the focus on medical readiness within the Services by removing the conflicting priority they face. Instead of facing incentives to protect a large asset base, the Surgeons General would be incentivized to focus on their core mission of maintaining readiness for war.

The typical way such a consolidation would be handled within the DOD structure is with an Agency or Field Activity. Examples of how this has been done in the past include consolidation of finance and accounting services in the Defense Finance and Accounting Service (DFAS), supply and logistical functions in the Defense Logistics Agency, the commissaries in the Defense Commissary Agency (DeCA), and information technology in the Defense Information Systems Agency. The logical choice for MTFs would be the already existing Defense Health Agency (DHA). Alternative options include placement within a military command (e.g., the maintenance depots, although these are Service specific) or creation of a new military Service (e.g., the German medical Service). Disadvantages of these two alternatives are that they mis-match the function with the structure, running hospitals is a commercial activity and military command structures are better suited for military essential functions.

Most of the examples mentioned above (finance and accounting services, supply functions, information technology, and depot maintenance) are consolidated in another way. In addition to their organization and management they are consolidated into a commercially oriented funding account. The current Defense Health Program (DHP) appropriation structure contributes to the challenges we face today. The DHP includes the consolidated operations and maintenance and procurement funding for the MTFs (a good start), but the funding is promptly divided across the Services in execution and not managed jointly. The DHP also consolidates a large portion of the funding for the readiness mission and largely leaves this inappropriate bundling in place as the funding is passed to the Services. The impact of this on resource allocation decision making includes:

- Healthcare benefits and medical readiness are put into a direct tradespace with each other, competing for resources against each other. Decision makers are forced to make tradeoffs between increasing medical readiness at the expense of the health benefit or vice versa, with no direct considerations of readiness more broadly or compensation more broadly.
- Medical readiness is removed from the tradespace of other readiness functions within each Service so that the Services cannot easily create a balanced readiness plan across medical and non-medical functions.
- Healthcare benefits are removed from the tradespace of compensation instruments (e.g., base pay, special and incentive pays, retirement, and quality of life programs) so that compensation cannot be easily understood and balanced across the range of compensation instruments.
- Unified resource management of MTFs is not achieved.

Consolidating the organization of the MTFs would provide an opportunity to consolidate and reform MTF funding (and reform funding for the entire Military Health System). Basic principles of funding and budgetary account structure include:

- Costs of personnel benefits should reside in MILPERS budget accounts.
- Costs of readiness should appear in Service readiness-related budget accounts.
- MTFs and other activities replicating commercial activities should be funded according to outputs produced, not inputs consumed.
- Costs should be recognized in the budget when the obligation is incurred.

MTFs are the last large support function in DOD that are still funded with an appropriated budget for inputs instead of for the outputs they produce. One way to consolidate MTF funding and improve incentives by funding for outputs is by placing them in a revolving fund. Another approach used for commissaries is a non-appropriated fund instrumentalities, which establishes them as a fiscal entity. Another, overlapping, option would be to convert the MTFs to government-owned, contractor-operated (GOCO) organizations with the contractor's payments based on healthcare delivered.

Reforming the Management of Military Hospitals

Consolidating organization/management and funding of MTFs would make a wide range of other, some inter-related, reforms easier. Examples of these additional reforms include:

- *MTFs should be professionally managed:* Organizing and operating MTFs like military units when the majority of the daily operations are the provision of beneficiary healthcare with little difference from civilian hospitals is inefficient. It fails to take advantage of the expertise resident in the healthcare sector at running medical facilities. A simple incremental step that could be taken as part of TRICARE reform is directing that a group of MTFs be placed under civilian management (e.g., as GOCO facilities) on a trial basis.
- *MTFs should face competition:* Competition is the ultimate disciplining force in markets, and lack of competition is a primary driver of inefficiency. Ensuring that the MTFs face competition for beneficiaries and care delivery would focus them on improvement. It should also be noted that this does not threaten readiness. The care the MTFs are primarily delivering and that would be at risk of moving to the private sector if the MTFs failed to effectively compete is obstetrics and other areas of beneficiary care that are not readiness related. In areas where DOD has invested in developing world-class readiness capabilities (e.g., burns and orthopedic rehabilitation in San Antonio), DOD should have no trouble competing for patients.
- *MTFs that cannot succeed in their mission should be downsized or closed:* Many MTFs today are not providing sufficient workload of the required case mix to support their readiness mission. For many of these, there is no reasonable or practical way to get the right workload into the facility and, thus, the facility will not be able to succeed in its mission. These facilities should be transitioned to clinics or closed.

Implementation Considerations for Military Hospital Reform

Consolidating the organization and funding of MTFs, and reforming their management, are major reforms that would require careful attention in implementation. Some examples of implementation considerations that will need to be addressed include:

- *Strategic Plan for the Direct Care System:* The number of MTFs with inpatient capacity has fallen by about a half since the end of the cold war. This change, however, was not analytically pre-planned; instead it was often the result of a struggle between some attempting to protect as much infrastructure as possible while Congress and DOD's leadership attempted to impose fiscal reality. Better results will be achieved if DOD could develop a plan identifying the direct care system mission, what its core infrastructure needs actually are, and how it plans to transition from the current state to the future state. Past efforts at this have not been rigorously implemented within DOD (e.g., labor and delivery care identified as a key element of readiness), so rigorous Congressional oversight of the plan development would be required.
- *Leadership:* Most defense agencies replicating civilian functions are civilian led, e.g., DFAS and DeCA (along with combat support agencies like the National Geospatial-Intelligence Agency). The DHA, perhaps inappropriately, has military leadership. Properly realigning leadership structure can be challenging (e.g., transitioning DeCA leadership from military to civilian), so it is valuable to get it right from the beginning.
- *Private Sector Management:* Considerations for the implementation of professional management that may include Congressional assistance include:
 - How to effectively manage the transition of existing government civilian staff.
 - Information technology inter-connectivity within the government and between the government and contractor.
 - Establishing standards for accreditation and consistency across the system.
 - Establishing realistic transition timelines that allow, for example, hiring the best personnel.

- Transparency and provision of data (e.g., providing 18 months of historic workload data to ensure full information about the market).
- Selection criteria for priority facilities include facility age and condition, individual product lines, community size, and community integration.
- *Isolated Locations*: Reforming MTFs in isolated locations (e.g., Ft. Irwin and Mountain Home) is a community integration issue, not a DOD infrastructure issue. The goal is market optimization across civilian and military populations, not stove-piped consideration of military infrastructure.

APPENDIX: MILITARY HOSPITAL CHALLENGES

The Military Health System (MHS) combines two primary missions. The operational or readiness mission is to provide medical care during wartime or other deployed contingencies. The beneficiary care mission is to provide a high quality healthcare benefit to military families and retirees. A core challenge of the MHS today is that these two missions continue to grow increasingly different from each other.¹

The MHS direct care system includes over 50 inpatient military hospitals and over 300 outpatient clinics. These Military Treatment Facilities (MTFs) sit at the intersection of the two primary MHS missions, they are supposed to serve as a skill maintenance venue of military medical personnel for the readiness mission by providing beneficiary healthcare. The increasing divergence of these two missions is making it increasingly difficult for the MTFs as currently organized and managed to fill this role. This puts MTF commanders in an almost impossible situation and creates a climate of confusion within the MHS that affects everything from staffing decisions to major investment decision making. Some simple examples of the confusion include:

- **Emergency Medicine**: Emergency medicine physicians had one of the highest physician deployment rates to Iraq and Afghanistan.² Some MTFs have the Emergency Department staffed with contracted civilian physicians while pediatrics and obstetrics are mostly military.
- **Outsourcing Surgical Workload**: Surgical workload is generally more relevant for maintaining the clinical skills of the military medical force, but MTFs generally outsource this workload to private sector care while retaining in house more care in areas like obstetrics. Table 1 illustrates this for three DOD markets, and it can be seen that obstetric workload is generally kept in house at over twice the rate of surgical workload.

Table 1.—Surgical versus Obstetric Workload Mix

Market	Surgical Workload			Obstetric Workload		
	Military Hospital	Purchased Care	% Military	Military Hospital	Purchased Care	% Military
Las Vegas, Nevada	1,315	4,749	22%	582	651	47%
Pensacola, Florida	657	5,403	11%	368	888	29%
Ft. Polk, Louisiana	192	203	49%	409	24	94%

- **Graduate Medical Education (GME) Programs**: The direct care system supports DOD-run GME or residency programs, but there is little attempt to focus these on operationally required specialty areas like trauma, surgery, emergency medicine, etc.

This confusion is an important driver of excessive costs in the MHS. The direct care system is expensive to operate, with the average MTF costing about 50 percent more to deliver inpatient care than it would cost to purchase that care in the local markets at current payment rates.³ Table 2 illustrates this cost difference for three markets in which DOD operates.⁴

¹The written testimony submitted of John Whitley for the hearing provides a more detailed discussion of this trend.

²Whitley et al., “Medical Total Force Management.” See Figure 2, p. 32.

³See Philip Lurie, “Comparing the Costs of Military Treatment Facilities with Private Sector Care,” IDA P-5262 (Alexandria, VA: Institute for Defense Analyses, 2016) (forthcoming). See Table 6, p. 27.

⁴Inpatient care is used for illustrative purposes. Comparisons of outpatient care yield similar results.

Table 2.—Military Hospital Inpatient Costs versus Private Sector Care

Market	Inpatient Military Hospital Cost	Cost of Purchasing Care in Local Market
Nellis Air Force Base, Nevada	\$34,624,144	\$29,909,465
Naval Air Station Pensacola, Florida	\$31,180,755	\$13,747,915
Ft. Polk, Louisiana	\$14,727,029	\$6,604,439

Source: Lurie, "Comparing the Costs of Military Treatment Facilities with Private Sector Care."

When the direct care system is successfully delivering its readiness mission, i.e., providing readiness training for the military medical force, this excess cost may be justified—a necessary cost for ensuring our warfighting capability. In cases in which the direct care system is not succeeding in its mission, this excess cost is a source of inefficiency in the MHS—wasting taxpayer resources that could be used to increase compensation or reallocated elsewhere in the defense budget for mission delivery.

DOD recently conducted an extensive internal study of the direct care system, finding that many MTFs did not have economically viable inpatient capacity and should be right-sized to the workload they can effectively support. This study, the *MHS Modernization Study*, was not able to directly assess the degree to which MTFs were meeting the readiness mission and instead focused on workload in major specialty areas. Although imperfect, this workload analysis provided a valuable “lower bound” measure for the readiness question—a hospital that does not have enough workload in a particular specialty area to maintain an economically viable capacity does not have enough workload to maintain the readiness of military providers in that area.

These challenges have caused a specific set of management problems in the direct care system:

- *Direct care system run as military units:* MTFs are led and administered as military units and justified by their readiness mission. In actual practice they are almost exclusively focused on beneficiary healthcare delivery. This misalignment of leadership and administrative structure with actual operations and functions means that the wealth of experience in civilian healthcare at running effective and efficient hospitals is not applied to MTFs. Professional business management of these large complex businesses is not used.
- *MTFs don't have to directly compete for business:* Private hospitals that cannot manage themselves effectively lose business and either get better or go bankrupt. MTFs are protected from this disciplining force of markets by simply being given bigger budgets to account for their inefficiency and attempts are made to coerce beneficiaries that choose to go elsewhere to return to the system.⁵
- *MTFs given a budget for inputs instead of paid for outputs:* Funding large DOD support missions that approximate commercial activities with direct appropriation for their inputs instead of on a reimbursable basis for outputs produced is a funding mechanism long ago abandoned in most other large support mission areas, e.g., logistics, financial services, and information services. MTFs still receive their funding according to the inputs they consume instead of the outputs they produce.
- *MTFs overuse military personnel for non-operational specialties:* The military medical force is overstaffed in beneficiary care areas like pediatrics and obstetrics. Military personnel are generally more costly than civilian personnel, so the unnecessary use of military personnel for delivery of beneficiary care is inefficient and drives higher costs.

Chairman MCCAIN. You also say that MTFs should be professionally managed. Does that mean you contract out to a management group? Is that what you are saying?

Dr. WHITLEY. I think that should be an option that is on the table and used in appropriate situations, Senator.

Chairman MCCAIN. Does that mean like in a pilot program? Would you recommend a pilot program where we contracted out for

⁵ See, for example, Amy Bushatz, “Families Forced to Give Up Civilian Health Care,” June 27, 2014. <http://www.military.com/daily-news/2014/06/27/some-families-forced-to-give-up-civilian-health-care.html>.

a non-military associated organization to conduct some of these functions?

Dr. WHITLEY. I would add, Senator, I think that should definitely be an option to consider. I would add that there are outpatient clinics that are operated that way today within the direct care system. Then I would add that—

Chairman MCCAIN. How is that working?

Dr. WHITLEY. My understanding is that the beneficiaries that use them are very pleased. I think the next panel can talk about their experiences with that from a management perspective.

Chairman MCCAIN. MTFs should face competition. This is pretty much along the same line of what we are talking about.

Dr. WHITLEY. Yes, Senator. I mean, the best way to motivate people to improve is to make sure that they know they are not the only game in town.

Chairman MCCAIN. How do you do that? The same way? A pilot program?

Dr. WHITLEY. Yes, sir. You could take specific markets and you could allow beneficiaries to choose among plans or choose between venues for where they are going to receive their care. It would be interesting to see what happens in those pilots. It would be interesting to see where the beneficiaries choose to go. It would be interesting to see what happens to costs in those markets, what happens to outcomes in those markets.

Chairman MCCAIN. For example, who would be the option?

Dr. WHITLEY. I am sorry, Senator.

Chairman MCCAIN. You say there would be other options that they would pursue. What would those options be?

Dr. WHITLEY. Civilian provision of the health care, Senator.

Chairman MCCAIN. Would that be in a private hospital or a private provider or a private insurer?

Dr. WHITLEY. I mean, all of the above. They could decide where to go for their primary care—that would be a primary care practice—where to go for their acute care. Yes, Senator.

Chairman MCCAIN. MTFs that cannot succeed in their mission should be downsized or closed. Has there ever been an MTF downsized or closed?

Dr. WHITLEY. There have been many, Senator. The direct care system is about half the size it was about 25 years ago.

Chairman MCCAIN. Twenty-five years ago, one was—

Dr. WHITLEY. It is about half the size. We are at about 55, 56, ballpark, bedded facilities, and we were close to 100 probably 20 years ago, Senator. Our folks coming in the second panel would have the numbers better than I would.

Chairman MCCAIN. To some degree, I think what you are talking about overall is competition.

Dr. WHITLEY. Yes, Senator.

Chairman MCCAIN. Right now there is none?

Dr. WHITLEY. There is some, and it manifests itself in various ways. I think it could be made much more explicit and it could be made much more of an effective tool for managing and for improving outcomes and the cost control in the system. Yes, Senator.

Chairman MCCAIN. Well, Mr. Chairman, I wonder if we ought to look at some of these recommendations at least as pilot programs as a beginning.

Finally, Dr. Whitley, do you think we should have a one-service medical corps or should we maintain three or four separate ones?

Dr. WHITLEY. I have to apologize, Senator. I am going to punt on that. I am willing to take a stand on competition. I have never personally studied the joint question. I have to punt on that one, Senator.

Chairman MCCAIN. Does each service not have a medical staff?

Dr. WHITLEY. Yes, sir, they do.

Chairman MCCAIN. Thank you, Mr. Chairman.

Senator GRAHAM. Senator Tillis?

Senator TILLIS. Thank you, Mr. Chairman. Thank you all for being here.

Dr. FENDRICK. I want to ask you a question. You in your testimony, both written and what you delivered before the committee, talked about value-based insurance design. That is something I got involved with down in North Carolina as a matter of public policy when I was speaker.

I want to talk a little bit more about that and how you think maybe State health plans that have done it, to the extent that you can and any member of the panel, have benefited from it.

If you could—it may not be related, but in the briefing materials, one thing that jumps out at me—and I would be interested in any of the panelists' opinions on this—are the discharge. The medical health system average annual inpatient discharges per 1,000 are some 61.7 for enrollees in the medical health plans and about 36. There seems to be a really big gap. Do you think that V-BID helps narrow that gap, or are there legitimate reasons why the gap is so great?

Dr. FENDRICK. I will first take the first half of the question about what is going on in the States, and maybe my fellow panelists can chime in about the level of optimism that V-BID might have to be part of the solution of this very important hospitalization problem.

First off, I think you pointed out that V-BID programs have reduced financial barriers to high-value services and providers in many of the States represented by this panel. I think it is important to point out that in the State of South Carolina, the Medicaid program has reduced cost-sharing for high-value drugs for the most vulnerable populations there. As Senator Gillibrand pointed out, the Empire State has highlighted V-BID in the State's innovation plan and its very important role in the State innovation \$100 million grant model. It is also highlighted in the Maine State innovation plan and is a very important part of the private sector Maine Business Coalition there.

You pointed out and we are very proud of the fact that V-BID plans are now offered to State employees in 13 States, including North Carolina. Of note, one voluntary V-BID plan was taken up by over 98 percent of State employees, and after 2 years, we saw marked increases in healthy behaviors, increases in preventive screenings, much clearly delineated consumer satisfaction. The good news is we are seeing emergency room visits and specialty visits decline.

I do not have information on hospitalizations because you know they tend to occur in a very compressed portion of the population. Those are often the people we are focused on more often and why we were so pleased to see a bipartisan, bicameral political support for a V-BID demonstration in Medicare Advantage, and we hope to be able study rigorously a V-BID program to actually lead to the reduction in re-admissions that you mentioned.

I think over the long term, we will see modest impacts on ER visits and hospitalizations, but I think much more importantly, you will be able to tell your constituents and the American taxpayers that the American health care financial situation is moving not to things that make people money but are finally moving in a very systemic way to services that make them healthier.

Mr. MCINTYRE. I would agree that providing incentives and direction for value-based incentives is the right thing to be doing.

You know, the thing that is interesting about TRICARE and about the DOD system is that not all the care is provided in one domain. That makes it uniquely challenging. The chairman of the full committee is not here at this juncture, but the Air Force went through a pretty massive re-footprinting process back at the beginning of TRICARE about 20 years ago. It did an amazing job of re-footprinting its installations. I think some focus on the question of what the sizing and the structure ought to look like and then what do you actually have to supplement it with to give elasticity from a provider perspective and then what types of providers and systems do you want. If you are going to have an integrated system that is in the private sector in a certain market, how do you plug that in? Because some of those delivery systems—their models really need to take care of the entire patient not just part of the patient's needs.

What I would also offer is that some of the prototypes of design that have been done over the last 20 years are worthy of exploration and assessment. There may be some new prototypes that need to be done, but I think there is probably a lot that has already been tested. Figuring out what its application might look like to end up making change as you go forward from here would be smart.

I will tell you I am particularly intrigued with the notion that you take the Defense Department for a population that it has need for and you take the VA for a population that it has need for, and in the same community, you are melding that together. There is a series of prototypes that have been in place for almost 20 years now that do that in different ways in about eight different markets. The Chicago approach kind of threads it all together. Then how do you bring the third leg to the stool?

Then you could go out to Gerald Champion in New Mexico. When Senator Domenici was a Senator here, there actually was a prototype that actually took a small community hospital in an Air Force location and actually took the airmen and put them in that hospital, took the VA folks, had them in that hospital delivering services in that environment doing operations there. Then the private sector was the third leg of the stool. It was the only prototype that was ever done like that.

You know the incentives in communities that are smaller or on their own—they ought not to be doing everything themselves—offers some real interesting assessment. I think you might find that there is a lot of fodder already there to step back and say how do we do this right. What are we missing in models, or do we have most of them already tested? How do we footprint forward with the right kind of make/buy requirements of folks before they start doing design and construction?

Senator TILLIS. Thank you, Mr. McIntyre. I think that was a great model.

Dr. Loftus, I am out of time. A part of what I was going to lead to is how would a high-performing health care system like Kaiser Permanente kind of play into that integrated solution. I think that that is a model that we have got to look at and develop, as Chairman McCain said, maybe through pilots. I do believe that helps us. I serve on the Veterans Committee. It is a very important topic. I think it is a way to target a lot of the needs in certain areas of the country.

Mr. Chair, the only comment I wanted to make—it may be something I bring up in the next panel, but there is just one more detail level thing I wanted to get on the record. Senator Gillibrand, I think this is something you may have looked at as well. The ABA treatment for persons with autism and the proposed rate cut is something that I am concerned with, the timing of it. I hope that either in this committee or in my discussions with the panelists outside of this committee that we go back and maybe be a little bit more methodical. I think that we may be making a mistake potentially cutting treatment options down below the national average and produce a bad outcome for something that I think has been proven to be highly effective and highly beneficial to those who take advantage of the treatment.

Thank you.

Senator GILLIBRAND. Thank you all.

Senator GRAHAM. Thank you. That was excellent.

Next panel, please. Thank you all very much for participating. It was very helpful.

[Pause.]

Senator GRAHAM. Thank you to the first panel. This is the second panel, and we will start with Mr. Woodson. I am going to have to run to another subcommittee hearing. I will turn it over to Senator Gillibrand, and I will be back as quickly as I can. Let us go ahead and get started. Mr. Woodson?

**STATEMENT OF HONORABLE JONATHAN WOODSON, M.D.,
ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS**

Dr. WOODSON. Chairman Graham, Ranking Member Gillibrand, members of the committee, thank you for placing the issue of military health system reform high on your agenda for 2016.

The military health system takes great pride in its performance in combat medicine over the last 14 years with greater than 95 percent survival rates for those wounded in battle. Our ability to prevent disease through exceptional primary care and preventive medicine services produced equally historic outcomes in reduction of disease and non-battle injuries.

The challenges we face in medicine and in national security, however, continue to evolve and require new approaches to be prepared for the future.

We have undertaken a number of initiatives to strengthen the military health system in all facets of its responsibilities, and they have been organized around six principal lines of effort, which we have spoken about in previous testimony. I, therefore, want to encourage that last year's Military Compensation and Retirement Modernization Commission reviewed and supported many of the initiatives that we have already set in motion in the Department. Let me briefly describe these efforts.

First, we have modernized our management systems with an enterprise focus. We established the Defense Health Agency that Vice Admiral Bono leads. The agency is entrusted with providing common business processes and standards and support of the military departments and combatant commanders, an approach that provides greater operational efficiency and ensures joint solutions to our customers.

We identified multi-service markets and developed 5-year business plans to promote common solutions and optimize the use of military treatment facilities while providing required care to beneficiaries in the purchase care sector.

In addition, we acquired and are now preparing to deploy a new electronic health record using commercial, off-the-shelf products. Together with the Surgeons General and Vice Admiral Bono, we have established an enterprise-wide dashboard to actively manage our performance in readiness, access to care, quality, safety, patient satisfaction, and costs. The Defense Health Agency achieved the milestone of full operating capability on 1 October 2015 and, in its first 2 years, saved over \$700 million.

Second, we are defining and delivering medical capabilities and manpower needed in the 21st century. With the services, the Department has embarked upon a thorough process to define essential medical capabilities and metrics to monitor readiness.

Third, as a result of the modernization study, we have analyzed infrastructure needs and right-sized several military treatment facilities, as well as made adjustments to move skilled medical personnel to markets where MTFs can recapture care, they can maintain their skills and reduce overall costs.

The fourth line of effort is perhaps the main focus of today's discussion, and that is our plan for reforming TRICARE. We are appreciative of the input from beneficiaries and service organizations that in recent testimony have expressed support for TRICARE. The TRICARE benefit was named as the number one health plan in the country for customer experience by Temkin in 2015, owing in no small part to the comprehensive coverage and low cost to our beneficiaries. By the way, we jockeyed for that position since 2011 with Kaiser Permanente.

We also have heard loud and clear from our beneficiaries that access to both primary and specialty care needs attention, particularly in the MTFs. In response, we have implemented a number of access improvement initiatives last year to open up more appointments, resolve appointment issues on the first call. We are improving access to after-hours care, particularly for child care, whether

that is through evening and weekend clinics, the ability to email providers questions through secure messaging, the availability of 24/7 nurse advice line that is integrated with our appointing system, streamlining the referral process, and implementing an urgent care demonstration program that Congress requested in last year's Defense Authorization Act.

Our T-2017 contract will be awarded in 2016 and includes provisions that further improve the experience of care for our beneficiaries. The PB-17 proposal provides choice and incorporates feedback from our stakeholder groups.

The fifth line of effort has been to expand strategic partnerships with civilian health organizations to enhance our ability to meet and exceed our responsibilities of readiness, quality, safety, and satisfaction. Partnerships with organizations such as the American College of Surgeons and the Institute for Health Care Improvement are providing tangible benefits that offer us ways to sustain our trauma system, improve clinical quality, and achieve our goals as a high reliability organization.

Finally, the sixth line of effort is focused on global health engagement where the Department is deeply engaged in national security threats posed by infectious disease and building bridges through health care around the world. We have contributed to the surveillance, prevention, diagnosis, and treatment strategies to combat well known outbreaks to include Ebola and now Zika, as well as ongoing efforts to prevent other outbreaks from occurring.

We entered 2016 confident that the reforms in the military health system and the health benefit can be further strengthened through a combination of legislative and operational reforms. I am grateful for this opportunity to be here today, and I look forward to your questions.

**STATEMENT OF VICE ADMIRAL RAQUEL C. BONO, USN,
DIRECTOR OF THE DEFENSE HEALTH AGENCY**

VADM BONO. Chairman Graham, Ranking Member Gillibrand, and members of the subcommittee, thank you for the opportunity to appear here today. I am pleased to represent the Defense Health Agency and explain how the DHA [Defense Health Agency] is contributing to the modernization of the military health system.

In November, I was honored to become the Defense Health Agency's second Director. Only a month earlier, the agency had reached full operating capability after 2 years of collaborative work with the Army, Navy, Air Force medical leaders, and with the Joint Chiefs of Staff that established the concept of operations for many of the functions of the agency. Our responsibilities center on supporting the military departments and the combatant commanders in the execution of their missions.

The Defense Health Agency was created in the recognition that most health care delivery is common across the Army, Navy, and Air Force, what we need, what we buy, what a best practice entails in both the clinical and administrative environments. The Defense Health Agency helps bring together common support functions into a new enterprise-focused organizational structure. We are able to help Dr. Woodson and the Surgeons General see and manage across the MHS in a more unified way.

One of the principal ways in which we deliver the support is through the operation of shared services. Critical enterprise support activities include TRICARE, pharmacy operations, health information technology, medical logistics, public health, medical R&D, education and training, health facilities, contracting, and budget resources management.

In addition to the ten shared services that have been implemented, the DHA has also brought in joint activities that had previously been distributed to the services that acted as executive agencies. These include the Armed Forces Health Surveillance Center, the Armed Forces Medical Examiner system, the DOD Medical Examination Review Board, the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, and the National Museum of Health and Medicine.

The DHA offers value, however, to more than our COCOMs and services. We serve as a single point of contact for many intra-agency, interagency, and external industry matters simplifying the process for our partners and outside colleagues to work with the Department of Defense in support of a number of imperatives such as research, global health engagement, adoption of emerging technologies, health care interoperability and more.

The existence of the DHA has streamlined engagement with the Defense Logistics Agency, Defense Information Systems Agency, and other field agencies. External to the Department, the DHA provides a single point of contact for operational matters within the VA, a number of agencies within HHS [Health and Human Services] to include Centers for Medicare and Medicaid Services, the Food and Drug Administration, the Centers for Disease Control and Prevention, Public Health Service, and more. We have successfully collaborated with the Justice Department on the prosecution of health care fraud cases, most recently with highly suspect activities around compound medications. We work with Treasury, State, and the GSA on a number of critical functions that directly support our health care mission.

I would like to focus on one shared service in particular, the operation of TRICARE, the military's health plan. TRICARE modernization is part of the MHS modernization plan that Dr. Woodson just outlined. We have a number of TRICARE initiatives already underway in 2016. Later this year, we will award the next round of TRICARE contracts known as T-2017, which is when health care will become operational under the new contracts. We are simplifying the contracts, reducing management overhead in both government and contractor headquarters by moving from three regions to two regions. We are expanding the means by which we manage the quality of our networks to ensure they meet the expectations for quality and safety that we expect for our beneficiaries whether in the direct system or in a private sector network.

We also will introduce innovative models for value-based purchasing in the coming year. My staff, in close collaboration with the services, is also crafting the contract amendments to permit TRICARE enrollees to use urgent care centers without pre-authorization. Our analytics team provides the Department's civilian, military, and medical leadership at the headquarters and field level

with the ability to assess the enterprise-wide performance of the military health system using agreed upon joint measures for readiness, health, quality, safety, satisfaction, and cost.

The DHA is now an integral and integrated part of the military health system. We are proud to contribute to the modernization of the system through joint collaborative solution and responsible management approach.

I am honored to represent the men and women of the Defense Health Agency, and I look forward to answering any questions you may have.

[The prepared statement of Dr. Woodson and Admiral Bono follows:]

PREPARED STATEMENT BY DR. JONATHAN WOODSON AND ADMIRAL RAQUEL C. BONO

Chairman Graham, Ranking Member Gillibrand and members of the Committee, I am pleased to discuss the Department of Defense's multi-year plan for modernizing military medicine in service to the 9.4 million Americans who rely on DOD for the delivery and coordination of healthcare around the world. I am honored to have Vice Admiral Raquel Bono, Director of the Defense Health Agency (DHA), join me in presenting this plan. I am proud to have the Surgeons General of the Army, Navy, and Air Force also accompany us at today's hearing and speak to the Service-specific issues for which they are responsible.

I want to thank the leadership of the Committee for placing military health care reform high on the agenda for action this year. There are a number of interconnected features of the Military Health System (MHS) that influence how we are organized, how we deliver and coordinate care, and how we interact with the broader American health system.

Over the last two and half years, the MHS has fully embraced an enterprise management approach to our work. Together with the Service Medical Departments and the Defense Health Agency, we have crafted strategies, policies, enterprise support activities, and leadership development programs that benefit the system as a whole. Our approaches to access, quality and safety are executed in a collaborative, interdependent manner. Operationally, where we work together in deployed environments or in multi-service markets, we increasingly ensure there is an integrated operating model that facilitates support to line commanders, to servicemembers and to our patients.

For our beneficiaries, we recognize TRICARE is an essential and valued piece of that health system. Both military medicine and the US health system are in a period of profound change driven by new discoveries, technological advances, and integrated delivery models aimed at increasing quality and controlling costs. Our proposals for modernization include both operational actions that we are undertaking right now, as well as legislative proposals that we have included in the President's budget.

TRICARE is essential to recruiting and retention and is an integral part of our overarching strategy for the MHS—the Quadruple Aim: Ensure Readiness, Improve Health, Improve Healthcare, and Lower Cost.

As we institutionalize the lessons learned from fourteen years of conflict, and as we implement a series of actions emerging from the Secretary's Review of the MHS, we must modernize our TRICARE program to better align with how medicine is delivered in 2016, and how patients expect to receive timely and high quality care.

DOD is taking a new approach to our reform efforts in 2016 and 2017. We are focused on defining value from the perspective of the patient. Emerging from the internal MHS Review, we have invested a great deal of time in understanding and evaluating our performance in access to care, clinical quality, and efficiency from our perspective as provider, insurer, and employer. In 2016, we are looking at healthcare delivery through the patient's lens, and developing systems and processes that are responsive to their needs.

Our starting point in our modernization plan is the recognition that TRICARE is a good health benefit that supports an exceptional group of Americans. Recent testimony by beneficiary organizations to Congress reinforced the view that TRICARE is one of the most comprehensive health benefits offered by any employer in the United States. While valuing the TRICARE benefit, beneficiaries voiced to Congress and to DOD that they particularly want to see improvements in access to care. We

have heard their concerns—and our reform strategy upholds the sacred promise we make to those who serve their country and to their families.

Congress and DOD have expanded eligibility, benefits and services under TRICARE over the 22 years it has been in existence. The most notable expansions include: TRICARE For Life—extending TRICARE benefits as second payer to Medicare for dual-eligible beneficiaries, TRICARE Prime Remote—offering Prime-like benefits to Active Duty families when they are stationed far from military installations; and TRICARE Reserve Select—offering certain Reservists with the opportunity to enroll in TRICARE with a modest premium payment.

We have tied our MHS modernization plan to our overarching strategic plan. Our MHS strategy continues to use the Quadruple Aim as our north star—Improved Readiness, Better Health, Better Care, Lower Cost. This is the framework I will use to describe the actions underway and those we have proposed.

THE MILITARY HEALTH SYSTEM: READINESS AT THE CENTER OF OUR STRATEGY

Over the last decade, the MHS performed superbly in providing combat casualty care and life-saving treatment, achieving historic outcomes in saving lives and preventing injuries and illnesses. Lessons from fourteen years of battlefield medicine, along with transformative changes in the practice of medicine in the United States, require new approaches to how we ensure medical readiness and how we best meet the expectations of our beneficiaries. We are continuously reevaluating and improving our approach to maintaining the health of the force, sustaining a ready medical force, and delivering quality healthcare to our beneficiaries—on the battlefield, on military installations, or in civilian healthcare settings.

The MHS is unique in our national health system. DOD operates a global system of hospitals, clinics, and health team—both fixed and deployable—to meet the health needs of *our military force, and to maintain the ability of our MSH to meet the readiness needs of the force as we continue to assess reform strategies to improve this primary mission.*

When we say “readiness” is at the center of our strategy—we mean: the medical readiness of individual servicemembers, the readiness of medical forces—and the need to build and sustain the clinical skills of the entire medical team so they are best prepared for whatever mission they are called to perform. Readiness also refers to family readiness. The health and wellness of our military families affects service-member readiness in direct and indirect ways. In 2016, we look at readiness from this broader perspective—with consideration for the family members’ viewpoint of whether our health system supports their own health goals.

TRICARE directly supports this readiness mission. In 2015, the Military Compensation and Retirement Modernization Commission (MCRMC) acknowledged the important role that MTFs have in sustaining the readiness of our medical forces. We have accepted a number of recommendations from the MCRMC and have launched a process to identify the essential medical capabilities needed to support the full spectrum of military operations.

One of the most important actions that we undertook during the Iraq and Afghanistan conflicts was the establishment of the Joint Trauma System (JTS). This system contributed significantly to the MHS’ ability to produce historic survivability rates for those wounded in action, and accelerated our ability to continuously improve combat casualty care research, training and practice. JTS will be embedded as an enterprise-wide system that provides essential support to our combatant commanders around the world.

Of course, not all MTFs include the full spectrum of medical or surgical capabilities. This requires that we augment MTF-provided care by purchasing health services from civilian healthcare networks managed through the TRICARE program.

In 2016, we plan to expand choices for our beneficiaries—allowing them the opportunity to more freely seek care from either military or civilian providers. There are a number of ways by which we can expand our service offerings. For example, retirees who are Medicare eligible can receive care in MTFs. Caring for these types of patients helps ensure military medical provider readiness. Likewise, resource sharing agreements with the Department of Veterans Affairs allow Veterans to receive care within MTFs, giving our military medical providers exposure to a more complex set of patient health needs. Other unique arrangements, such as civilian access to our Level I Trauma System and burn center at San Antonio Military Medical Center, ensure that our providers remain current with best practices in trauma and burn care—important skills to maintain for military operations. In other external resource sharing arrangements, military providers obtain admitting privileges at nearby civilian institutions, where they can provide a wider range of care for our beneficiaries, also allowing for clinical skills maintenance.

Although the MHS is an indispensable element of national security, the TRICARE feature of beneficiary choice also includes the choice of beneficiaries to receive all of their care from civilian providers. In some circumstances, this choice is driven by necessity—where beneficiaries reside in areas not near a military installation. In other circumstances, beneficiaries simply elect to receive civilian care even when military medical facilities are nearby. Some military retirees use other systems of care beyond TRICARE: the health care afforded to Veterans through the VA, the health insurance product provided through their employer, or the Medicare program. For those beneficiaries who elect to receive all of their care from civilian sources, whether by choice or circumstance, we are interested in exploring ways to direct beneficiaries to accessible, high quality providers.

The MHS is a complex web of relationships that extend beyond DOD to include other federal health partners as well as the civilian community. This integrated system of care requires relentless attention to the development of leaders with skills to operate in the joint environment. We recently reviewed our leadership development programs and identified the need to better integrate and sequence these programs. I have directed our leadership team to put together a revised curriculum for leadership development in the joint environment that focuses on the development of management skills that further ensure readiness, improve health, access, and quality and responsibly manage cost.

MHS MODERNIZATION: BETTER HEALTH

MHS modernization recognizes that our health system can be made even better; and that the delivery of accessible, high quality care, matched with exceptional customer service, is part of our mission, not secondary to it.

Our multi-year modernization plan offers a significant advancement in how the MHS will be a leader in healthcare delivery and customer service in the country. Our modernization plan raises customer service performance levels; improves health; further expands choice; simplifies the process of getting care and offers additional new ways to access care; ensures access to the latest healthy technology; helps direct patients to the highest quality of care; and continues to offer value at an out-of-pocket cost to our people that is lower than virtually any health plan in the country.

DOD has already begun its multi-year modernization of the TRICARE program. First, we will continue our efforts to prioritize health ahead of healthcare.

TRICARE has always had excellent coverage of important preventive services—and we're making it better. Most of our preventive services are available without any cost share. For example, any beneficiary (Prime / Extra / Standard / TRICARE For Life) can get required immunizations from any provider, to include retail clinics. We are going to expand the ease and coverage of even more services in the coming year, and ensure our preventive services plan is fully aligned with the Affordable Care Act provisions.

TRICARE MODERNIZATION: BETTER CARE

There are a number of components of health care delivery that are focused on better care. Access, quality and safety are among the predominant components in which we will dedicate our energy and resources in the coming year.

Access—Easier, Patient-Centered. We are overhauling every aspect of our how our patients get care—whether primary or specialty care.

Our patients deserve high quality care delivered safely and expeditiously. Yet, we frequently hear about problems accessing health care within the MHS. In our internal review, we heard that patients are concerned about being told to call back for an appointment, and dissatisfied with delays in getting care because of a cumbersome pre-authorization and referral system.

During the MHS Review, we found that MTFs generally meet defined access to care standards on average. However, there was a great deal of variation—there were MTFs that did not meet these standards and others who consistently performed better than the standard. In 2015, we incorporated two measures of access into an enterprise-wide, “Partnership for Improvement” dashboard, which is reviewed monthly by me and the other MHS leaders present today.

The same access standards apply to both MTF provided care and TRICARE Prime care delivered in the private sector. Assessment of purchased private sector primary care access is largely determined from patient experience surveys. According to survey data, individuals who use TRICARE Standard or Extra are more satisfied with the care provided when compared to those who use TRICARE Prime. In 2016, we will be exploring beneficiary concerns more deeply by engaging focus groups on specific subjects.

Recent Congressional testimony from beneficiary groups suggests that the lower satisfaction with TRICARE Prime is related to the inability to get an appointment at an MTF and to the associated referral and authorization processes. NDAA 2016 called for improving access in the following ways: 1) make it easier for beneficiaries to move among the identified TRICARE managed care support contract regions; 2) allow TRICARE Prime *beneficiaries access to urgent care centers without a preauthorization* requirement under a pilot project; and 3) expand the public transparency of quality, safety and satisfaction information.

We have taken a number of steps to improve access to care. We implemented “first call resolution” policies ensuring that the appointment or referral will be completed during the initial call for beneficiaries enrolled to our patient-centered medical homes. I issued initial guidance for simplified appointing and first call resolution on June 2, 2015. We have already begun to see the positive effect of these changes from the patients’ perspective. Performance monitoring will ensure compliance and survey data is letting us know if our beneficiaries are satisfied with the results.

We are not simply monitoring our performance from this one action. We have put a number of policy and operational actions into motion already this year.

The Services and DHA undertook a listening tour to MTFs and with beneficiaries around the country. We learned a great deal from these visits. The Services and DHA have identified that peak hours of physician supply do not always match patient demand. In response, we are extending hours to evenings and *weekends in a number* of our MTFs. We have increased the number of urgent appointment by 32 percent since May 2015, and we have expanded the overall number of appointments by more than 11 percent.

Part of our enterprise approach is to effectively use the demonstration authority that Congress has provided us and pilot new approaches to patient care delivery. We recognize that patients, particularly those with complex or chronic medical conditions, require ongoing services from a mix of primary care and specialty providers. I am directing demonstration projects in which we evaluate the use of “integrated practice units (IPUs)” into our medical homes. The most important feature of the IPU is that it organizes medical services around the patient’s needs and medical condition rather than organizing medical services from the health system’s perspective.

Contemporary access to healthcare is no longer confined to the four walls of a doctor’s office or dictated by drive time standards. Instead, information technology offers a variety of opportunities for patients to engage the medical system. Providers can extend their reach to treat or advise their patients beyond the clinic’s open hours or without requiring distant travel. Furthermore, many of these modalities offer new opportunities to support the warfighter wherever they are deployed. In January 2016, I expanded our policies to encourage greater use of telehealth, and permit its connection to the patient’s home. The new policy will enhance our abilities to provide telemedicine services and expand access for our beneficiaries.

In 2014, we established a Nurse Advice Line (NAL) for all of our beneficiaries. This new capability now fields 1,800 calls per day (significantly higher than we projected, and higher than most commercial health plans). Call volumes are increasing each month. Many patients, after engaging with the NAL, do not subsequently seek emergency care, but wait to be seen at their Primary Care Medical Home at the MTF. For those whose symptoms suggest a true emergency, the NAL activates the emergency medical system and stays on the phone until help arrives. Additionally, the 24/7 NAL is integrated with our appointing and referral systems, ensuring beneficiary have round-the-clock access to healthcare advice and appointing services. We plan to expand the services offered by the NAL in the next year to increase convenient access.

The TRICARE program has leveraged web-based technologies to provide beneficiaries with information, secure ways to enroll for health care services, review claims, pay bills, and even make appointments. Patients can communicate with their providers using secure messaging services and download their medical records using Blue Button technology. We are ensuring that all primary care providers and most specialists use and promote the secure messaging capability with their patients. The new electronic medical record will add even more functionality for patients.

In 2016, the MHS will begin to deploy smart phone applications that will make it easy for our patients to contact their providers, access all of the TRICARE Online capabilities, and find useful information about the nearest MTF. We will also launch new telehealth capabilities that will allow providers to consult with their patients using video technology, along with capabilities for providers to securely monitor

their patients' health remotely (e.g. blood pressure monitoring or other biometric data).

DOD will also implement a pilot program that allows enrollees to access urgent care centers without requiring a preauthorization, consistent with NDAA 2016. I am confident that these additional means of access—both virtual and physical—will have a significant, positive affect on satisfaction with accessibility and customer service among our Prime population.

For patients who receive referrals from their primary care providers, we are also streamlining referral processes so that patients will be advised of referral approval in a more timely way.

We are also proposing to allow beneficiaries who live more than one hour away from an MTF to enroll for care at those facilities. While we believe that patients should live in close proximity to their primary care provider, we also believe that patients should be able to choose their provider, even if the provider is more than an hour's drive away. However, we will retain contract provisions that require the civilian network to be constructed in such a way as to ensure easy geographical access, to the extent possible, for our beneficiaries, using existing drive time standards.

In our fiscal year 2017 proposed budget, we introduce a new approach to the DOD health benefit that further simplifies the program for beneficiaries. Patients would be able to choose between a managed benefit that prioritizes care in the MTFs (and continues to offer MTF care at no cost to beneficiaries), and an unmanaged option that sustains the freedom of choice for beneficiaries to seek civilian care without restriction.

Our initiatives are intended to ensure retention of our existing enrollees as well as increase use of military treatment facilities for all beneficiaries. Our customer service enhancements are intended to encourage our beneficiaries who live near a military hospital or clinic to come back to the MTF.

Finally, in 2016, we will also award the TRICARE-2017 (T-2017) contracts, with healthcare delivery slated to begin in 2017, allowing for a 12-month transition period between contractors. T-2017 is another element in our efforts to simply program management, reduce administrative costs, incentivize value and ensure quality with our network providers. We have also streamlined processes for portability, helping ease beneficiary transition as they move from installation to installation. We will reduce TRICARE regions from three to two, eliminating unnecessary administrative overhead for both the government and contractors.

Quality of Care. The MHS is *proud of the quality of care we deliver*. The MHS Review found that the MHS performed well along the quality and safety parameters studied. However, similar to our findings on access, we found wide variation across MTFs and across safety and quality measures. Like health systems everywhere, we know we can improve further. We will.

We have implemented a number of important measures to achieve that objective. In 2015, we standardized quality and safety measures across the enterprise and can now compare performance across all MTFs. We are now amending our TRICARE contracts to establish similar reporting for private sector care. Senior leaders monitor performance on a monthly basis.

MTF commanders are being provided with tools to both educate their staffs and monitor their performance. We are expanding participation in the American College of Surgeons (ACS) National Surgical Quality Improvement Program (NSQIP) to all MTFs with surgical capabilities. This partnership provides these MTFs with insights into improving surgical mortality and morbidity. In the coming months, we will provide the Institute for Healthcare Improvement's (IHI) Global Trigger Tool (GTT) to all MTFs to proactively assist in identifying potential safety concerns.

When serious chronic illness, medical conditions, special needs or injuries require a comprehensive coordination of care across multiple providers, beneficiaries will be assured of a personal case manager who will assist with coordinating care wherever it is provided—with other military hospitals, in the civilian sector, or with the VA.

The Department is going to adopt or introduce value-based payment demonstration projects in 2016. In 2015, we opened discussions with the Centers for Medicare and Medicaid Services (CMS) to explore how we can participate in several of the innovative payment reform initiatives that CMS has introduced over the past several years. By aligning efforts with other federal initiatives focused on value-based payment, we can leverage the extensive research that led to these demonstrations. The complex rules related to payment formulas have been incorporated into contractor-operated, federal claims processing systems. Several of the bundled payment demonstration projects—such as the recent CMS demonstration around bundled payments for joint replacements—hold the most promise for the populations that we

serve. We will provide the Committee with regular updates on our progress in this area.

Comprehensive information on service delivery—access, quality, safety and satisfaction—is available online to the public for the military health system as a whole with some limited information visible at the MTF level. Additional information will soon be available at the MTF, consistent with the direction from the Secretary of Defense and the NDAA 2016. We have engaged and will continue to engage our military and veteran beneficiary organizations in how we might present this information in ways that make the information more relevant and easier to understand. We encourage our patients to ask us questions about our quality and safety record, and to engage in questions about their own plan for health. The DHA is working with CMS to place MHS performance information on Hospital Compare to provide another outlet where our performance information will be publicly shared. We are incorporating beneficiaries into our quality management activities.

The MHS has identified six communities where there is a significant military medical presence by more than one Service Medical Department. We refer to these communities as “multi-service markets.” Collectively, over 40 percent of all care we deliver in DOD medical facilities occurs in these markets and an equally significant amount of care is purchased from the private sector in these markets. We have provided senior medical leaders in these markets with enhanced authorities to coordinate service delivery; standardize appointing and referral policies; and reallocate local resources to best meet beneficiary needs. We have achieved some early successes in these markets relative to access to care and patient satisfaction.

These multi-service markets are major deployment platforms, and we similarly plan to use them as platforms for innovation. They reach across Service-specific populations and the lessons we learn from innovating in these markets can be more rapidly shared across the enterprise.

Health Benefits and Technological Advances—Leaning Forward. Healthcare is changing fast. With the generous support of Congress, TRICARE has been made more flexible and more adaptive to the changes in technology to advance health. DOD now has greater authorities to approve emerging technologies for coverage. We have already started this process—for laboratory-developed tests and for other promising medical procedures. Where the medical evidence is present, we will look to do more.

We are ensuring that TRICARE’s mental health and substance use disorder benefit meets current standards of care and—like our preventive services benefits—align with the Affordable Care Act, Mental Health Parity Act and other federal health legislation. We have already eliminated the limit on inpatient behavioral health bed days, and we will finalize policies to ensure parity in other areas in 2016.

One of the most important advances we will introduce in 2016 is the first phase of deployment of our new Electronic Health Record (EHR) in the Pacific Northwest. This multi-billion acquisition represents a major milestone for the Department. Our decision to purchase a commercial, off-the-shelf product provides DOD with a system that will support our journey to high reliability, allow ongoing private sector innovation to be incorporated into future releases, and support our interoperability objectives in sharing information with both the VA and with private sector providers. The EHR will also feature an advanced patient portal, providing our patients with easier access to their own health data—and improve their ability to manage their care.

Support for Children with Special Needs. Over the last several years, we have modernized TRICARE and the Extended Care Health Options (ECHO) program, expanding services to retiree families and eliminating financial caps on services. We are continuing to improve our complex case management services, with a particular focus on the unique needs of military families and frequent relocations.

TRICARE for Reservists. Issues regarding continuity of care, and continuity of coverage, for Reserve Component families have been raised by both the Reserve community and in the Military Compensation and Retirement Modernization Commission report in 2015. Although the TRICARE Reserve Select program has been well received and offers an excellent health benefit, the Department continues to explore opportunities that can accommodate those Reserve members and families who would prefer to retain their existing provider relationships.

TRICARE Support. In October 2015, the DHA reached Full Operating Capability. The TRICARE Health Plan is one of the principal enterprise support activities—or shared services—for which the DHA is responsible. Working closely with the Service Medical Departments, we are better able to coordinate policy and operational decisions in support of TRICARE changes in a more agile and transparent manner. Our other enterprise support activities—pharmacy operations, health information technology, medical logistics, health facilities, public health, medical research and devel-

opment, medical education and training, contracting, and budget & resource management—also provide essential support services to both combatant commanders and the Services.

I would like to highlight just one element of how this enterprise support better enabled critical support in a crisis. In 2015, the MHS witnessed an alarming escalation in prescription drug costs, largely related to increased utilization of compound medications. The DHA monitoring system identified potential fraudulent activity; recommended and concurrently implemented a series of enterprise-wide screening procedures in our military pharmacies, mail order and retail network that precipitously and safely reduced inappropriate fills of compound drug prescriptions; and coordinated with the Department of Justice in the prosecution of fraudulent actors and the recovery of funds.

Cost—Responsible, Moderate Changes in Beneficiary Cost-Sharing. The full complement of improvements and services that we have put forward also requires investment. Most of these additional costs will be borne by the Department. For example, the implementation of shared services led the Department to reduce defense health costs by \$3.5 billion over five years, savings that have already been decremented from our proposed budget.

Since TRICARE and then TRICARE For Life were introduced, the percentage of care delivered in the private sector rather than in DOD medical facilities has grown. Today, over 60 percent of all DOD-funded health care is delivered in civilian settings through TRICARE. The integration of care delivered in military and civilian settings is—and will remain—a necessary feature of military medicine. We will continue to assess our partnership with our civilian network and the impact of its prominence upon our direct care facilities, recognizing cost efficiencies where possible. Over the last several years, overall defense health program costs have been well managed, with actual costs coming in less than projected at the beginning of the year.

Although costs have stabilized in recent years through both management actions on the part of the Department and a general slowdown in US healthcare inflation, National Health Expenditure projections, a product of the Centers for Medicare and Medicaid Services, anticipate a gradual increase in per capita health care costs to roughly 5 percent in coming years.

The Department has submitted several reform plans since 2005, largely to control health care costs. Last year, the submission of the President's Budget (PB) 2016 benefit reform proposal was relatively well received. The PB 2017 health benefit reform proposal leverages the PB 2016 proposal but makes some important adjustments. Following are the attributes of the PB 2017 proposal.

- A simpler system—provides beneficiaries with two care alternatives and overall less complexity in their health plan. TRICARE Select is an HMO-like (managed) option that is MTF-centric and TRICARE Choice is a PPO-like (unmanaged) option offering greater choice at a modestly higher cost.
- Economically emphasizes TRICARE Select leveraging MTFs as the lowest cost option for care to make full use of Direct Care capacity and also provides needed workload for military providers for readiness training.
- No change for Active Duty—who would maintain priority access to health care without any cost sharing but would still require authorization for civilian care.
- Copays—will depend on beneficiary category (excluding Active Duty) and care venue; it is designed to minimize overutilization of costly care venues. There would be no copays in MTFs to facilitate the effective use of military clinics and hospitals and thereby improve the efficiency of DOD's fixed facility cost structure. There would be fixed network copays for the TRICARE Choice option without a deductible.
- Participation fee—for retirees (not medically retired), their families, and survivors of retirees (except survivors of those who died on Active Duty). They would pay an annual participation fee or forfeit coverage for the plan year. There is no participation fee for Active Duty members or their family members. There is a higher participation fee for those retirees choosing the TRICARE Choice option (\$200 higher).
- Open season enrollment—similar to most commercial plans, participants must enroll for a 1-year period of coverage or lose the opportunity.
- Catastrophic caps—which have not gone up in 10 years would increase slightly but still remain sufficiently low to protect beneficiaries from financial hardship. The participation fee would no longer count towards the cap.
- Medically retired members and their families and survivors of those who died on Active Duty would be treated the same as Active Duty family members (ADFM), with no participation fee and lower cost shares.

- To ensure equity among ADFMs, the proposal offers all ADFMs a no cost medical/surgical care option regardless of assignment location and zero copays for ADFM emergency room use, including in the network.
- The Department will offer a second payer option with a lower fee for those with other health insurance.
- Fees and copays will be indexed at the National Health Expenditures (NHE) per capita.

There have been no changes to most cost-sharing elements of the TRICARE Program since it was established in 1994. At the time TRICARE was introduced, retiree family beneficiary out-of-pocket payments accounted for approximately 27 percent of total TRICARE health care costs. Today, retirees and their families only bear 8 percent of the costs, and our proposal raises that share to 10.5 percent of total costs. For Active Duty families, the changes are even smaller, moving out-of-pocket costs from 1.4 percent of total costs to 1.6 percent. By any measure, these changes are modest, responsible adjustments that place the Department's health program on a stable, long-term financial footing and preserve the foundation of the health system and its platforms for ensuring a medically ready and ready medical force.

We enter 2016 confident that an excellent health benefit can be further strengthened through a combination of legislative, policy, and operational reforms. Our health benefit plays an important role in readiness as well as recruiting and retaining the men and women in uniform who serve this nation.

The MHS continues to *serve as a unique and indispensable national security asset. It supports our Active Duty force and it retains its clinical skills through an Active clinical practice in both peace and war.* It offers a ready asset to respond to humanitarian assistance needs and disaster response. The full complement of preventive, public health, primary care, specialty and specialty care services that we offer are necessary components for meeting the national security obligations of the United States.

Our *health benefit must continue* to ensure a ready medical force of military providers and support staff able to deploy anywhere, anytime with skills that support combatant commander requirements; provide access, choice and value of the health care benefit, and be fiscally sustainable for the Department.

The MHS reforms we have outlined today will help us meet the appropriately high expectations that beneficiaries have for us. Service members, military retirees and their families are right to expect affordable, accessible quality health care is available to them from both military or civilian providers, wherever they reside. We are committed to increasing value from their vantage point.

Our proposal represents a balanced, comprehensive package of reforms that are directly aligned with and address each element of our Quadruple Aim. We have initiatives that will improve readiness, improve health, improve care, and lower cost. We look forward to working with you over the coming months to further refine and articulate our objectives in a manner that improves value for everyone—our warfighters, our combatant commanders, our patients, our medical force, and the American taxpayer.

Thank you for inviting the Surgeons General, Admiral Bono and me here today to speak with you about the essential linkage between our readiness mission and our health benefit, and about our plans to further improve benefits and services for the long term.

STATEMENT OF LIEUTENANT GENERAL NADJA Y. WEST, USA, SURGEON GENERAL OF THE ARMY AND COMMANDING GENERAL U.S. ARMY MEDICAL COMMAND

LTG WEST. Chairman Graham, Ranking Member Gillibrand, and distinguished members of the subcommittee, thank you for this opportunity to provide the Army Medicine's perspective on defense health care reform.

It is an honor, first I would like to say, to serve as the Army Surgeon General and Commanding General of the U.S. Army Medical Command.

Since 1775, Army medicine has supported our Nation and our Army whenever and wherever needed. However, today I would like to focus on our more recent history.

For the past 14 years, we have supported an all-volunteer force engaged across the globe and supporting the joint campaign fighting in Iraq and Afghanistan and responding to national disasters and other contingencies such as the U.S. Government response to the Ebola outbreak in West Africa. We have accomplished this while continuing to attract, educate, and train the next generation of Army medicine. We are collecting what we have learned over the past 14 years and ensuring that we are using these lessons to inform our daily efforts and how we prepare for the future.

Our readiness to serve when needed is my number one priority. In assuring our readiness, Army medicine must maintain medical capabilities that are ready to deploy and support our warfighters.

During the past 14 years of combat operations, we have achieved a survivability rate, as you heard Dr. Woodson mention, of 92 percent, the highest in the history of warfare despite the changing tactics of our adversaries and the increasing severity of battle injuries. We are not going to lose the knowledge and the best practices that helped us achieve the survivability rate. These advances in combat casualty care resulted from our integrated health services that span the continuum of care from prevention to treatment of illness and injury and to recovery and rehabilitation in both the garrison and the operational environments.

We cannot, however, focus exclusively on sustainment of combat trauma, surgery, and burn capabilities. Our experience shows that the Army must be agile and adaptable and therefore must maintain a broad range of medical capabilities to support the full range of military requirements.

To that end, we see our medical centers, hospitals, and clinics as health and readiness platforms. They ensure we maintain trained and ready medical personnel by exposing them to a diverse and broad range of patients with a wide variety of illnesses and injuries.

Our medical centers also serve as platforms for our Army graduate medical education programs. These programs are the primary means for transferring the knowledge from this generation of military providers to the next. While we focus on our readiness mission, we must also ensure we provide our soldiers, their families, and our retired population with access to high-quality health care that meets their needs and encourages health.

Improving access to care is a priority for Army medicine, and I have directed actions to rapidly improve access to care.

First, we will enable our beneficiaries to book an appointment up to 6 months in advance, and we have already piloted that at some of our installations. Womack Army Medical Center is one example. We will increase the number of available appointments by increasing the time our providers are available to see patients and reducing the number of unfilled appointments and also working on the no-show rate, which leaves a large number of our appointments unfilled and unutilized.

Additionally, we are opening three new community-based medical homes and we will evaluate where after-hour or urgent care clinics are necessary.

As part of the health services enterprise, we will also continue to expand our telehealth program. We are currently conducting a

pilot to treat low acuity patients in the emergency department at Fort Campbell as one example. We are also expanding remote health monitoring programs and leaning forward to expand our telehealth to the home. I would like to thank Dr. Woodson for recently signing the policy to help us expand that facility to home telehealth initiative.

I understand reforms are necessary to ensure the long-term sustainability of TRICARE. However, reforms must not increase the financial burden on our Active Duty soldiers or their Active Duty family members and must minimize any impact to our retired population. Reforms should encourage beneficiary use of our direct care system to ensure our medical military skills are maintained and should also encourage healthy behaviors, as you have heard our colleagues mention previously.

Reforms must not degrade our combat-tested system or readiness in an environment where we must remain rotationally focused and surge ready as the next large-scale deployment could be tomorrow. General Milley states that the Army's fundamental task is like no other. It is to win in the unforgiving crucible of ground combat.

Now, Army medicine does not literally fight wars. I understand this. We are, however, a critical enable to ensure our Army achieves this end. Our Nation's mothers and fathers know that when their sons or daughters become ill or injured, we are there, we are ready, and this gives them the confidence to send them into harm's way if called. This is a truly sacred trust, and our readiness to support the warfighter can never, will never be in doubt.

I want to thank you all for your continued support to our soldiers and to military medicine, and I look forward to your questions. Thank you.

[The prepared statement of General West follows:]

PREPARED STATEMENT BY GENERAL NADJA Y. WEST

Chairman Graham, Ranking Member Gillibrand, and distinguished members of the subcommittee, thank you for this opportunity to provide Army Medicine's perspective on defense health care reform and to discuss our efforts to improve Army Medicine. Army Medicine's clear objective remains to enable the readiness of our Army. We do so by ensuring our soldiers, past and present, and their Families receive the care they need while continuing to improve access and quality of health care for all beneficiaries.

No other health care organization could have accomplished what Army Medicine has done since 2001. For the past 14 years we have supported an All-Volunteer force fighting the wars in Iraq and Afghanistan, responded to natural disasters across the globe, and deployed to other contingencies such as the US Government response to the Ebola outbreak in West Africa. While caring for soldiers and their Families we continued to embrace our retirees and veterans and ensured their pressing healthcare needs were met; even at the height of the wars.

We do not rest on our laurels and today we must address the need for healthcare reform to ensure we maintain the lessons learned over the past 14 years and prepare for tomorrow's conflicts while continuing to provide a sustainable healthcare benefit to all who have earned it. We owe it to our soldiers and their Families to ensure any changes to the military health benefit honor their sacrifices and preserve the long-term viability of the All-Volunteer Force.

READINESS

The global security environment continues to degrade and to place high demands on the United States Army. The Army must be prepared to confront near-peer competitors abroad, defend the Homeland, and respond to a wide range of crises, ranging from peacekeeping to disaster relief and humanitarian assistance. Throughout

last year, the Army committed approximately 190,000 soldiers to over 140 countries and to Homeland defense to advance our national security interests.

The Army derives its power from the collective strength of its soldiers. Our soldiers are our primary weapon systems and ensuring they remain medically ready, trained, and prepared to deploy is our number one priority. Therefore, Army Medicine has a two-fold readiness mission. We must ensure soldiers are medically ready to deploy while maintaining medical forces, complete with trained personnel and equipment, to deploy and support our Nation's Army.

During the past 14 years of combat operations, our trained and ready medical providers contributed to a survivability rate of 92 percent, the highest in the history of warfare, despite the increasing severity of battle injuries. These advances in combat casualty care resulted from our integrated system of health that spans the continuum of care from the battlefield to our inpatient hospitals in the United States.

However, it would be a mistake to focus exclusively on sustainment of combat trauma, surgery and burn capabilities. Our experience shows that the Army must maintain a broad range of medical capabilities to support the full range of military requirements. From 2001 to 2015, only 16 percent of those evacuated from Iraq and 21 percent of those evacuated from Afghanistan were injured in battle. The remaining Service members were evacuated for disease or non-battle injuries. Similarly, greater than 95 percent of those that received care and remained in theater were treated for disease and non-battle injuries rather than combat injuries.

The 2014 deployment of over 2,500 personnel to support Operation United Assistance in Liberia demonstrated the value of non-trauma related medical specialties and the importance of force health protection in deployed environments where a major threat to our soldiers is infectious disease rather than armed combatants. The geographically endemic medical risks to our forces in support of the rebalance to Asia and continued operations in Africa point to the continued need to remain ready to utilize the entire spectrum of Army medicine in the execution of all manner of military contingency operations.

Our medical centers, hospitals and clinics are our health and readiness platforms. They ensure we maintain trained and ready medical personnel. Our large medical centers serve as specialized training centers for our medical teams to provide care and clinical research for complex battle injury and illness. Our medical centers are complemented by a variety of military treatment facility types, from ambulatory clinics to community hospitals, to ensure our medical force is capable of providing primary and routine specialty care in the myriad of settings and conditions faced around the world. These facilities must be capable of providing a broad range of patients with a wide variety of illnesses and injuries.

Our medical centers also serve as platforms for our Army Graduate Medical Education (GME) programs that are critical to develop trained and ready medical personnel. GME programs are vital to our ability to recruit and retain highly skilled medical providers. Army GME is the largest GME platform in the DOD and supplies more than 90 percent of all staff Medical Corps (MC) Officers for the Army. Our GME programs have nearly 1,500 trainees in 149 programs across 10 Army Health and Readiness platforms. Civilian GME programs do not have the capacity to absorb our interns, residents, and fellows. Our GME programs continue to lead the nation in training. The first time board certification pass rate of 95 percent across Army GME exceeds the 87 percent national rate. Agile GME program management assures ongoing alignment of training slots with deployment and readiness requirements.

Reducing our beneficiary population to only Active Duty will result in an inability to sustain our GME programs due to lack of teaching cases and exposure to the wide breadth of disease within each specialty necessary to support any residency training program. Of the current 1.34 million beneficiaries enrolled to Army Medicine, 66 percent are non-Active Duty Service Members (ADSMs). Excluding behavioral healthcare, 80 percent of our total inpatient workload and 70 percent of our high-acuity inpatient workload is for Family members, Retirees and other non-ADSMs. Additionally, non-ADSMs comprise 50 percent of total outpatient care, and 53 percent of our general surgery cases. The Active Duty population at most Army installations, comprised mostly of healthy young adults, is insufficient to maintain an inpatient hospital. Therefore, nearly all of our 22 inpatient MTFs would need to transition to outpatient clinics. Even at the largest Army installations, the case mix presented by a young, relatively healthy Active Duty population would be insufficient to maintain the medical skills of our providers.

Beyond trained physicians, our deployable Combat Support Hospitals and Forward Surgical Teams require trained allied health professionals, nurses, OR [Operating Room] techs, lab techs, and other specialties that operate as teams and maintain their skills in our MTFs. The loss of inpatient capability would pose significant

risk to the maintenance of their skills and directly impact the readiness of our operating force medical units. Training, once lost, cannot be replaced.

The Army recognizes the need to maintain the skills learned over 14 years of war to ensure these capabilities do not atrophy, while also ensuring that we maintain the full scope of medical capabilities needed to be flexible and adaptable to all future globally integrated operations. In conjunction with my fellow Service Surgeons General and the Joint Staff Surgeon, my staff is working to identify, define, categorize and prioritize the medical capabilities required to support future conflicts and contingencies. Readiness measures will be developed and reported in systems of record, such as the Digital Training Management System (DTMS) and the Defense Readiness Reporting System-Army (DRRS-A).

HEALTH BENEFIT REFORM

TRICARE is an excellent benefit tailored to support our beneficiaries and their unique needs and situations. However, most agree that change is necessary to ensure the long-term sustainability of the program and to improve performance. I support the TRICARE reforms proposed in the Fiscal Year 2017 President's Budget.

Reforms should inspire beneficiaries to return back to our direct care system and military run medical facilities. I believe the best place for them to receive care is in our military treatment facilities where we understand their needs, can manage and document their care, ensure quality, and can ensure their readiness.

Reforms should incentivize health and healthy lifestyles. This is key to long-term cost control.

We must ensure our beneficiaries have access to high quality, safe healthcare in our MTFs and in the TRICARE network. To this end, we must increase transparency and exchange of data between both healthcare systems.

Reforms must not increase the financial burden on Active Duty soldiers or Active Duty family members. Any increased financial burden on retirees must be modest and not inhibit them seeking necessary medical care in our facilities.

Reform also provides the opportunity to identify and close gaps in the benefit. In some cases legislation established benefits for Active Duty but excluded similar benefits for Retirees or Family Members. In other cases, civilian insurance programs now provide benefit coverage for new or emerging technologies and treatment modalities not yet covered by TRICARE. TRICARE should be one of the most comprehensive health plans in the country and exceed all benchmarks under the Affordable Care Act. Our beneficiaries deserve nothing less.

IMPROVING ACCESS

Improving access to care remains a priority for Army Medicine. Specifically, our beneficiaries expect better acute care access. While we have made significant improvements in access, 21 percent improved since 2014, we are still not meeting our beneficiaries' expectations. Therefore, I have directed actions to radically improve access to primary care in our MTFs. I have established a goal of creating 260,000 (4 percent) more primary care visits above the 6.1 million visits we provided in fiscal year 2015 and 119,000 (1.5 percent) more specialty care visits above the 7.9 million we visits provide in fiscal year 2015.

We are standardizing processes across our enterprise to continue to drive improvement with access. Last year, Army Medicine instituted a first call resolution policy to ensure all enrolled beneficiaries receive a direct care appointment or network authorization on their first call. In addition, Army Medicine implemented a simplified appointing policy to reduce the types of primary care appointments from 12 to 5, with the vast majority of these being 24 hour acute appointments and future or follow-up appointments.

Army Medicine continues to expand our off-installation healthcare program by placing Community Based Medical Homes (CBMH) in communities surrounding our military installations closer to where our beneficiaries live and work. Today over 10 percent of our enrolled beneficiaries receive their primary care in a CBMH, many of which have extended hours and offer behavioral health, physical therapy, and prescription refill services. We currently have 20 CBMHs supporting 13 installations. In fiscal year 2016, we will open three (3) more CBMHs at 3 installations and in fiscal year 2017, we will open two (2) more CBMHs and our first open access acute care clinic in San Antonio.

To further improve access for routine care and specialty care, I have directed my staff to evaluate the feasibility of opening appointments beyond the current six-week template to six (6) months or more. This will allow beneficiaries to depart at the conclusion of their appointment with follow-ups booked in advance without the need to call back in the future. Additionally, we are also conducting a comprehensive as-

assessment across our installations to determine where expansion of clinic hours or establishment of Urgent Care Clinics is necessary.

We are partnering with the Navy, Air Force, Defense Health Agency, VA and other institutions to improve access as well. In San Antonio the Army will lease and outfit a CBMH that the Air Force will staff and run. We are also hiring civilian physical therapist and technicians to work in Air Force facilities. In Puget Sound the Army is hiring medical providers to work in Navy facilities. The Army is providing analytics and finance & accounting support to the National Capital Region Medical Directorate under the Defense Health Agency. We are providing staffing and analytic support to the enhanced Multi-Service Markets.

Army Medicine will continue to seek opportunities to leverage technology to enhance access for our beneficiaries. In fiscal year 2015, Army Telehealth (TH) provided over 40,000 provider-patient encounters and provider-to-provider consultations across 18 time zones in 30 specialties over 30 countries and territories including the operational environment.

In fiscal year 2016, Army Medicine will initiate a pilot to utilize TH to assist with overused Emergency Departments (ED). This pilot will utilize primary care physicians from Fort Gordon to treat patients with low acuity at Fort Campbell. This will allow the ED physicians to concentrate their efforts on patients with higher acuity and should drive down ED wait times.

The true promise of TH lies in the potential to reach patients in their homes. On February 3, 2016, the Assistant Secretary of Defense for Health Affairs signed a memorandum authorizing TH to a patient's home. We are leaning forward to develop implementation guidance to execute expansion of TH to the home.

IMPROVING QUALITY AND SAFETY

Since 1775, Army Medicine has been a reliable capability for our Nation, our Army and all those entrusted to our care. Army Medicine, in 2012, began working to implement the tenets of the "High Reliability Organization" (HRO) to continue to evolve our understanding of patient safety. In 2015, we established the Deputy Chief of Staff for Quality and Safety to align all quality, patient safety, and organizational environmental and equipment safety elements within the same directorate. This alignment provides a synergistic environment to take advantage of analysis of problem areas and best practices across the full spectrum of quality and safety from within the command and in consultation with external experts and leaders.

Army Medicine is collaborating with The Joint Commission to pilot an assessment to gauge the HRO maturity of four Army MTFs. The team completed three assessments in 2015, and one in January 2016.

Army Medicine is increasing its participation in the American College of Surgeons' National Surgical Quality Improvement Program (NSQIP) to reduce surgical complications, improve outcomes, and improve patient satisfaction. Currently, nine (9) Army MTFs participate in NSQIP. By the end of 2016, all 22 Army MTFs with surgical services will participate in NSQIP. In 2015, Dwight D. Eisenhower Army Medical Center at Fort Gordon, GA was recognized by the American College of Surgeons as a top NSQIP performer and deemed "Meritorious" with regard to their composite quality score.

To drive further improvement, MEDCOM will design, develop and implement a Quality and Safety Center to more effectively use patient safety data, improve sharing of lessons learned across the MEDCOM, and increase transparency and availability of quality and safety information available to our leaders, staff, and beneficiaries. This center will be established in coordination with the Army Combat Readiness Center and will leverage many of the successful practices incorporated by the CRC.

IMPROVING PERFORMANCE

Since 2010, Army Medicine has maintained relatively stable enrollment of 1.4 million beneficiaries despite significant budget and personnel turbulence. As we improve access, quality, and safety, Army Medicine is also improving performance to maximize value. From fiscal year 2011 to fiscal year 2015, our operations and maintenance budget decreased from \$7.6 billion to \$7.0 billion. After reaching a high of over 43,648 civilian personnel in January 2013, MEDCOM lost 5,140 civilian personnel due to the furlough and hiring freeze in 2013 and 2014. MEDCOM civilian end strength has slowly risen back to our authorized civilian end strength of 40,583 that we require for mission accomplishment. DOD imposed constraints on the number of staff we can employ is a limitation to our capacity and, therefore, to our ability to improve access.

Army Medicine is driving performance improvement at the MTF through the use of an innovative financial incentive model and performance based resourcing called the Integrated Resourcing and Incentive System (IRIS). IRIS aligns resources, funding and incentives to enhance MTF value production and adjusts resources based on actual performance compared to MTF business plans. IRIS financially rewards high-performance and incorporates quality measures through financial incentives to the facility for achievement in Evidence Based Practice standards, data quality, patient satisfaction, and continuity of enrollee primary care encounters.

STREAMLINING STRUCTURE

Army Medicine continues to evaluate its headquarters structure to ensure it is properly sized and aligned to support the Army. In Fall 2013, the AMEDD Futures Task Force was established to review the MEDCOM headquarters structure and provide recommendations on how to best balance and align the headquarters structure. The Task Force recommended a flattened and more integrated structure that is geographically aligned to support the Army. The Secretary of the Army approved this reorganization on 27 April 15 and MEDCOM initiated its transformation on 8 July 2015.

By the end of the two year implementation in fiscal year 2017, the MEDCOM will transform from 20 to 14 subordinate Command HQs. This 30 percent reduction of headquarters will reduce our administrative overhead structure to less than 4.2 percent of MEDCOM's total requirements and authorizations. We will transform from fifteen functional regional command HQs to four multi-disciplinary Regional Health Commands (RHCs) by merging regional headquarters for public health and dental into the RHCs to create a single point of accountability for Health Readiness that is strategically aligned with the Army's operational force headquarters and units. Finally, we will transition the headquarters for the Public Health Command, Warrior Transition Command, and Dental Command to elevate and integrate them into key staff on the MEDCOM headquarters.

Simultaneously, a work group was established to review the executive leadership within our MTFs. The results of this study led to an executive leadership model borrowed from the US Navy, the AMEDD Health Executive Leadership Organization Structure (HELOS), which was approved for implementation on 12 Jun 15. The model standardizes the leadership structure for medical centers, large hospitals, small hospitals, and clinics. It provides increased leadership opportunities at the deputy level and enhances oversight of quality, safety, the patient experience, staff development, and productivity within all MTFs. The new leadership positions will provide additional opportunities to groom future hospital and medical center commanders. The endstate will be more experienced leaders who are more accountable.

CONCLUSION

Army Medicine is one of the finest health care systems in the world. As the military health care reform discussion continues we must remain focused on maintaining readiness while continuing to improve the health of all those entrusted to our care. While our system has proven very successful over the last 14 years of supporting the Warfighter, we need to continue to improve and evolve it to meet the changing needs of our Nation's Army. No other health organization is required to provide, nor is capable of providing, the full spectrum of care from point of injury or illness on a battlefield through rehabilitative care while continuing to maintain high quality care in garrison environments for its beneficiaries. There is more we can do to improve readiness, enhance the benefit and ensure fiscal sustainability within our existing authorities. We remain fully committed to work with Congress, DOD, and all those entrusted to our care to improve our system.

I want to thank my partners in the DOD, the VA, my colleagues here on the panel and the Congress for your continued support.

STATEMENT OF LIEUTENANT GENERAL MARK A. EDIGER, USAF, SURGEON GENERAL OF THE AIR FORCE

Lt. Gen. EDIGER. Chairman Graham, Ranking Member Gillibrand, and distinguished members of the committee. Thank you for the opportunity to come before you today to discuss the future of the military health system.

We fully support the committee's work to enhance the focus on value and delivery of the health benefit to those we serve, con-

sisting of sustained good health, streamlined patient experience, readiness of the force we support, and the readiness of our medical force.

Strong health systems must continuously improve. Changes to the Air Force performance management process implemented in 2015, as part of the coordinated action plan following the military health system review, are producing continuous improvements in safety, quality, and timeliness of care. Recent evidence includes the joint commission of our hospital at Joint base Elmendorf-Richardson for outstanding performance on key quality measures, the Keesler Medical Center's top 10 percent ranking among all U.S. hospitals participating in HCAHPS [Hospital Consumer Assessment of Healthcare Providers and Systems] measures of patient perspectives, and favorable system-wide performance against national benchmarks in perinatal outcomes, diabetes management, and well child care. We know our performance as a health system is integral to our readiness, and we remain committed to continual improvement.

Today we have 683 medical airmen deployed around the world providing medical support to contingency operations, including the trauma team at Craig Joint Theater Hospital in Bagram, Afghanistan, mobile surgical teams at various sites, and aeromedical evacuation teams with critical care capability.

Our success in support of deployed operations is inextricably linked to the care we provide in our hospitals, our clinics, and our many partner institutions. The bedrock of our readiness is the military hospital. Of the 76 Air Force military treatment facilities, only 13 today are hospitals. I would add that 30 years ago in 1986, we had 73 hospitals. Over the past 30 years, the Air Force has closed and converted 60 hospitals.

Our capability to meet combatant command requirements with deployable medical teams hinges primarily on our eight largest hospitals. The broad scope of care we provide to retired military members, their families, and veterans is key to our readiness. The Air Force has a number of agreements with the VA under which we provide specialty care to veterans. As we consider changes to the military health system, we believe it is very important to facilitate retiree access to specialty care in military hospitals and provide tools enabling more agreements with the VA and other Federal health systems.

To ensure our readiness, we have evolved to a model in which Air Force surgeons and critical care specialists devote a portion of their time to provision of care in partner institutions, such as VA medical centers and level 1 trauma centers where more complex care and trauma are prevalent. I would offer as an example the medical group at Nellis Air Force Base in Las Vegas where the surgeons on staff at Nellis, vascular surgeons, orthopedic surgeons, and general surgeons, do a significant portion of their cases in the VA medical center in Las Vegas but also at the University Medical Center in downtown Las Vegas, which is the only level 1 trauma center for Las Vegas. This provides the needed balance of complex cases for a proficient, deployable clinician.

An additional key point pertains to primary care support for Active Duty families. Experience has shown that primary medical

support to Active Duty families from our military treatment facilities enhances commanders' efforts to support families under stress and strengthens the resilience of families. As changes are considered, we strongly recommend sustaining care for Active Duty families in military treatment facilities.

I thank the committee for its steadfast support and dedication to the welfare of the airmen, soldiers, sailors, marines, their families, and our veterans. Thank you.

[The prepared statement of Lieutenant General Ediger follows:]

PREPARED STATEMENT BY LIEUTENANT GENERAL MARK A. EDIGER

Chairman Graham, Ranking Member Gillibrand, and distinguished members of the Committee, thank you for the opportunity to come before you today, to discuss the future of the Military Health System.

We look forward to supporting the committee's work to enhance the delivery of the health benefit that is so vitally important to those who serve and have served our nation. Initiatives to structure health care delivery around provision of value hold great promise for those we serve. We fully support the pursuit of streamlining measures to improve access and the experience of care. For the Military Health System, value in provision of care equates to better health and performance for those we serve, as well as readiness of the medical force for mission support. I will focus my comments today on our strategies to meet the future needs of the Air Force and Joint Team. I will describe linkages to our readiness and our support to military operations that we believe to be important considerations as options are assessed for delivery of the health benefit. The Military Health System is unique in that its mission couples direct medical support to military operations around the globe with delivery of health care. Our care is provided to a very special population whom we are honored to serve. Today we have 683 medical airmen deployed around the world providing medical support, even as we provide care and operational support from our 76 military treatment facilities at Air Force installations. Additionally, Air Force medical personnel conducted 61 global health projects in 2015, including a significant role in the U.S. response to the Ebola crisis in West Africa. Our history has clearly demonstrated that our success in support of deployed operations is inextricably linked to the care we provide in our hospitals and clinics. As we embark on change, we recommend careful assessment of the options that enhance our readiness and our support to Active Duty families.

With a focus on the future, the Air Force has published the Strategic Master Plan and Future Operating Concept for the U.S. Air Force. These documents reflect a dramatic transformation in capabilities already in progress. Also, the Joint Staff has published the Joint Concept for Health Service Support. These documents shape our strategies in Air Force Medicine to enable a force capable of the following:

- Stabilization of casualties in austere forward locations with the agility to stabilize during patient movement
- Integration of human performance enhancement as part of the development of airmen
- State of the art, highly reliable specialty care with particular focus on operational health
- Precision prevention-focused health services to members and their families
- Continuous linkage of health data across all domains of medical support during and beyond Active service
- Global health response in support of national strategies

In 2015, we saw indications these forecasted requirements are valid as the scope of counter-terrorism operations shifted medical requirements in the combatant commands.

Our strategic actions to evolve to these capabilities are mapped and include four major initiatives currently in progress:

1. Full spectrum readiness in the medical force—incorporating clinical readiness standards into management of readiness for the medical force
2. Integrated operational medical support—extending medical support into the operational environment for missions with special performance requirements and/or operational health issues. This includes operations conducted from Air Force installations such as Integrated Strategic Reconnaissance
3. Trusted Care—application of high reliability principles in Air Force Medicine focused on the safest, highest quality care

4. Air Force Medical Home—progressive primary care leveraging new knowledge for precise, timely prevention and teammate-based care for airmen and their families

There are two key points I wish to make in regard to our readiness. Both points are relevant when considering potential changes to the Military Health System. The first point relates to our hospitals and second relates to our support to Active Duty families.

To sustain a deployable medical force in support of combatant command requirements, the Air Force uses a variety of tools that include partnerships with numerous trauma centers and academic medical institutions. These partnerships have proven valuable and will continue to move forward, but the bedrock of our readiness is the military hospital. Of the 76 Air Force military treatment facilities, only 13 are hospitals. This represents a dramatic transformation from the early 1990s, when most Air Force military treatment facilities were hospitals. This means our capability to meet combatant command requirements with deployable medical teams hinges on our remaining hospitals, primarily our eight largest hospitals. Those hospitals are the primary source for expeditionary Air Force hospitals and critical care transport teams. Furthermore, these Air Force hospitals are essential to our disaster response and humanitarian assistance capability.

Research and innovations in deployed trauma stabilization surgery and movement of critical care patients originated in military hospitals and those innovations have advanced standard practices internationally. In order to keep our medical professionals at these hospitals current in clinical skills needed to support combat operations and global health missions, they must provide care in our hospitals to patients from beyond our Active Duty population.

The readiness of our medical force is significantly dependent on the care we provide to retired military members, their families and veterans. The Air Force has a large and growing number of agreements with the VA under which we provide specialty care to veterans. We have more readiness-based capacity in specialty care to make available to retirees and veterans at our hospitals. As we consider changes to the Military Health System, we believe it is very important to facilitate retiree access to specialty care in military hospitals and provide tools to enable more agreements with the VA and other federal health systems.

My second key point in regard to readiness pertains to primary care support for Active Duty families. Air Force leadership is committed to excellent primary care medical support to Active Duty families. Experience has shown that primary medical support to Active Duty families from our military treatment facilities enhances commanders' efforts to support families under stress, and strengthens their resilience. This is particularly important when the Active Duty member is deployed. The Air Force Medical Home is our strategic initiative to provide the best primary care support, and prepare for future opportunities presented by advancing science in identification and mitigation of health risk. As changes are considered, we strongly recommend sustaining care for Active Duty families in military treatment facilities.

We also know timely access to primary care services for our population is a priority for the committee. It is a priority we share and has been a focal point over the past year for coordinated improvement across the Military Health System. In collaboration with the Army and Navy, we have implemented policy changes to improve appointing processes, and implemented a common performance management dashboard.

In the Air Force, we have implemented changes that have increased the fill rates for primary care provider positions. We give top priority to operational health requirements, which requires a significant portion of dedicated primary care bandwidth. A recent example is the addition of separation health examinations to support disability applications by separating Airmen at a rate approaching 3,000 per month. The Air Force performs 80 percent of these examinations on Airmen while the VA conducts 20 percent. We remain committed to managing our primary care resources to provide good access to care while meeting operational health requirements for Airmen. We are also committed to streamlining referral management processes to speed the provision of specialty appointments to our patients.

We appreciate this opportunity to describe our initiatives for meeting the requirements of the rapidly evolving U.S. military capabilities. We are particularly grateful to discuss the many facets of our readiness and relevant linkages connected to delivery of the health benefit. As the committee considers revisions to the Military Health System, we stand ready to provide information or assist. I thank the committee for its steadfast support and dedication to the welfare of the airmen, soldiers, sailors and marines we serve.

**STATEMENT OF VICE ADMIRAL C. FORREST FAISON III, USN,
SURGEON GENERAL OF THE NAVY AND CHIEF, BUREAU OF
MEDICINE AND SURGERY**

VADM FAISON. Ranking Member Gillibrand, distinguished members of the committee, it is my honor to represent the men and women of Navy medicine, 63,000 dedicated professionals who every day honor a trust in caring for those who have sacrificed to defend our freedom. We are grateful for your strong and unwavering support of our servicemembers and their families.

As you consider potential changes to the military health system, I thank you for that, but I would like to highlight important considerations that I believe are central to any discussions.

Military readiness and combat support are our mission. Navy medicine protects, promotes, and restores the health of sailors and marines around the world at home and deployed and in all warfare domains. We are equally privileged to care for their families.

In an increasingly complex world, as our Navy and Marine Corps stand ready and engaged around the globe, Navy medicine stands there as well to protect and to care for them. As an agile, rapidly deployable medical force, this is what sets us apart from civilian health care. No civilian health care company in the world routinely leaves their families and home on a moment's notice to willingly go into harm's way to care for those in need. No health care company in the world daily puts their lives on the line in battle to defend and care for their patients, as the young hospital corpsman 2nd class was privileged to see awarded the Silver Star 2 weeks ago did without thinking. No health care company in the world experiences the staff deployments and turnover we routinely experience and still delivers world-class care. Finally, no health care company in the world is daily and singularly focused on the combat readiness of its staff.

The proof is on the battlefield, the highest combat survival in recorded history. Wounded warriors are alive today who, in any previous conflict, would have died from their injuries. They are the testament to the effectiveness of the military health system because every one of them, from point of injury on the battlefield to advanced treatment in our medical centers, received their care from men and women who got their training, their experience, and their preparation in our military treatment facilities. Those facilities are the foundation of battlefield survival. In my opinion, as a former commander of a deployed expeditionary combat medical facility, a robust military health system is critical to future battlefield survival. Unparalleled combat survival in our Nation's longest conflict is proof that a robust military health system that also serves as our training and search platforms for our battlefield providers from corpsman to physician is essential to both combat survival and agility in rapidly supporting our deploying operational forces.

These three facts are not in dispute.

One, we have the highest combat survival in recorded history.

Two, many wounded warriors alive today would have otherwise died of their injuries in any previous conflict.

Three, every wounded warrior received their care from injury on the battlefield to recovery in our medical centers exclusively by

men and women who receive their training, their clinical experience, and preparation in one of our military treatment facilities. This is a system that works and has proven itself time and again in the thousands of men and women alive today.

It is also a system that is not perfect, and I appreciate your attention to this much needed area of reform and improvement. The services are working hard to improve access, care continuity, convenience, and satisfaction with the care and benefit that we deliver in peacetime. We have made important strides in each of these areas while concurrently increasing enrollment, network recapture, staffing realignments, and other efforts to ensure we provide the clinical experience our staff needs to preserve skills, competencies, and ultimately combat survival in the next conflict.

It is more than just trauma. 70 percent of the evacuations in the most recent conflict were not trauma-related. Every single person on our team, every single person wearing a uniform in the Navy today matched to an operational platform is assigned to an operational platform. We do not have people in uniform for peacetime care. All of them have necessary roles and responsibilities in the next conflict.

More needs to be done, and none of us underestimates the effort required to improve our peacetime health care services. We are committed to continuing those necessary reforms which will improve our patients' experience and, most importantly, their health. However, we must do so without putting at risk the very system which has yielded such unprecedented survival. We will need your help in this effort, and for your tireless support, I thank you for helping us to ensure that those sailors and marines who will stand the watch in the future will have the same or better survival than today's wounded warriors have had. In our hands is a sacred trust to do all in our power to return home safely America's sons and daughters who have sacrificed to defend our freedom. I thank you for helping us to honor that trust today and tomorrow.

[The prepared statement of Vice Admiral Faison follows:]

PREPARED STATEMENT BY VICE ADMIRAL C. FORREST FAISON III

Chairman Graham, Ranking Member Gillibrand, distinguished Members of the Committee, thank you for providing me the opportunity to offer some perspectives on military medicine. All of us recognize that this Committee has been a strong and unwavering advocate for the men and women in uniform and we are particularly grateful for your support of the Military Health System (MHS). As you continue your important oversight role and deliberate on potential reforms to Defense health care, I would like to highlight some important considerations which I believe must remain in the forefront of any discussions.

The President's Budget for fiscal year 2017 contains key TRICARE proposals which are needed to modernize the Department's health care program. I support these reform proposals as they will continue to sustain military readiness, improve beneficiary choice, and improve access as well as help realize cost savings. In addition, these initiatives will simplify TRICARE while encouraging the use of military treatment facilities (MTFs)—vital for medical readiness—and update beneficiary out-of-pocket costs with modest increases. These proposals will strengthen the Military Health System (MHS) and support sustainable health care benefits for all our beneficiaries.

We recognize, however, that the proposed legislative changes must be complemented by internal changes and institutional reform efforts within the MHS that allow us to deliver exceptional, more convenient care to our beneficiaries. We are at a pivotal point. We must aggressively assess the transformative opportunities presented in today's environment to provide value-based care, employ technologies

that make good clinical and business sense and eliminate administrative processes that can negatively impact access to care. The MHS leadership is committed to making these necessary internal reforms that will improve beneficiary experience, and more importantly, beneficiary health.

MEDICAL READINESS IS OUR MISSION

Navy Medicine protects, promotes and restores the health of sailors and marines around the world, ashore and afloat, in all warfare domains. We exist to support the operational missions of both the Navy and Marine Corps. These responsibilities require us to be an agile, rapidly deployable, expeditionary medical force capable of meeting the demands of crisis response and global maritime security. The Chief of Naval Operations (CNO) and Commandant of the Marine Corps (CMC) expect Navy Medicine to keep their sailors and marines healthy, medically ready to deploy and to deploy with them. They, along with the combatant commanders, must always be confident in our capability to deliver world-class care, anytime, anywhere. This obligation to keep our Nation's servicemembers and their families healthy is both a privilege and sacred trust earned over years by providing care at sea, on the battlefield and around the world in our medical centers, hospitals and clinics.

These demands set us apart from civilian medicine – we are truly a mission-ready, fully integrated medical system. This capability allows us to support combat casualty care, working side-by-side with our Army and Air Force colleagues, with unprecedented battlefield survival rates, as evidenced over the last 15 years. Our operational agility also enables us to rapidly meet global health threats as we did in deploying mobile labs and personnel to Liberia that slashed the Ebola virus testing time from days to hours. In addition, our hospital ships, USNS [United States Navy Ship] *Mercy* and *Comfort*, are capable of getting underway quickly for combat support or to support humanitarian assistance and disaster response efforts here and around the world, as evidenced by relief efforts in the Gulf Coast following Hurricane Katrina, Indonesia in the aftermath of the tsunami, and in Haiti following the devastating earthquake.

OUR MILITARY TREATMENT FACILITIES ARE THE FOUNDATION OF OUR READINESS

We must recognize that the direct care system—our CONUS [Contiguous United States] military treatment facilities (MTFs)—are our most important readiness training platforms. These facilities are critical to sustaining the vital skills and clinical competencies for our medical personnel who are saving lives on the battlefield. I cannot overstate the importance of robust clinical experience to having a fully trained and ready medical force capable of sustaining unprecedented survival on the battlefield. From physicians to nurses to corpsmen, our personnel want to deliver health care and need that strong clinical experience to sustain and enhance their skills in preparation for the next deployment. These CONUS MTFs provide important surge capabilities, while our OCONUS [Outside Contiguous United States] facilities support our forces operating forward much like our expeditionary medical capabilities onboard ships.

As a ready medical force, we have a responsibility to ensure we are as ready for the next mission or conflict. The improved battlefield survival rates we realized over the last 15 years of war were the result of highly trained, properly equipped medical personnel from our MTFs who had the capabilities to rapidly implement combat casualty care best practices and lessons learned. These outcomes were achieved and then sustained by the collective hard work by the men and women of military medicine and the critical resources provided to us by Congress. Our challenge remains holding these important gains moving forward.

We are leaning forward to improve the effectiveness and efficiency of our CONUS MTFs to provide that robust clinical experience to preserve skills and competencies by moving more workload in-house, growing our patient enrollment, rebalancing staff and investing in our graduate training programs. This also has a side benefit of reducing overall private sector care expenditures. Our implementation of the Navy CONUS Optimization Plan resulted in the realignment of personnel, services, and graduate medical education (GME) programs at several of our MTFs to better sustain the operational readiness skills of our provider teams and optimize primary and specialty care services for our patients. I believe the fiscal year 2017 budget proposals will enable us to continue these efforts since they incent the use of the direct care system.

Access to care for our beneficiaries is crucial to these efforts. Integrated and comprehensive primary care delivery is an important foundation in achieving cost efficient, accessible, and high quality health care. Nearly all of Navy Medicine's 790,000 MTF enrollees are receiving care in a National Committee for Quality Assurance

(NCQA)-accredited Medical Home Port (MHP). These patients have seen an improvement in same-day health care access with their MHP team, augmented by virtual access via e-mail communications with providers and access to a 24/7 Nurse Advise Line (NAL) and telehealth.

As a result of this enhanced access, readiness, health outcomes and patient satisfaction have improved while unnecessary emergency room usage has decreased. We have expanded this by establishing Marine-Centered Medical Homes (MCMHs) and Fleet-Centered Medical Homes (FCMHs) to enhance access and care for our operational forces. These teams also integrate behavioral and psychological health care providers to improve medical readiness. We currently have 23 MCMHs and five FCMHs with efforts under way to expand to additional locations in 2016.

I believe an erosion of our direct care system would have significant adverse consequences on our ability to sustain medical force skills and competencies. This will have direct negative impact on our medical readiness capabilities and also potentially degrade our ability to recruit and retain our medical professionals. We need to recognize that comprehensive beneficiary care in our MTFs is directly linked to skills sustainment of our medical force and, from that, survival on the battlefield. Our beneficiaries, by agreeing to get their care in our MTFs, are helping to ensure we save lives on the battlefield in the next conflict.

MEDICAL RESEARCH AND DEVELOPMENT AND MEDICAL EDUCATION ARE FORCE MULTIPLIERS

In addition to the direct care system, investments in education and training are critical for meeting our current requirements and ensure that wherever our staff are deployed, they are well prepared. Our GME programs are among the nations' best and our young corpsmen are training with medics and airmen at the top-tier Medical Education Training Campus (METC) in San Antonio.

Cutting-edge R&D [Research & Development] and innovative medical education are hallmarks of military medicine and directly enable our readiness mission. Over the years, some of medicine's most important breakthroughs have come from Navy R&D programs and this work continues today in our labs around the world. Ongoing research and development ensures the Navy and Marine Corps force is better protected, operational tempo is more effectively sustained, and, when needed, the rehabilitation of our ill and injured is continuously improved. Along with our MTFs, medical education and research and development are foundational to our system and form an important triad of excellence within Navy Medicine. Collectively, these capabilities are vital for our mission of force health protection.

A RAPIDLY EVOLVING HEALTH CARE LANDSCAPE

We must recognize the transformation currently underway in health care. We are witnessing rapid changes in clinical care brought about by innovations in disease diagnosis and treatment. Advances in areas such as digital imaging, genetics, precision medicine, pharmaceuticals and therapeutics are all having significant impact on the delivery and cost of patient care.

In addition, we know that our patients want convenience and, where possible, use of virtual technology to support their health care needs. This is the impact of the millennials on health care and it is not unique to the military although we are more impacted by it because of our patient demographics: Based on our most recent available data, 72 percent of enlisted sailors and 85 percent of enlisted Marines are 30 years old or younger. They and their families are very comfortable with digital technology and expect to incorporate their smart phones and tablets into their daily health care transactions whenever possible. Moving forward, traditional portals of care within our direct care system and the supporting TRICARE networks must be complemented with innovative and interconnected technological approaches to provide virtual outreach and care, including handheld device apps and telehealth.

Our priority must remain the health of the force, their families, and those we serve. This commitment is not volume-based or supply-driven. It's a patient-centered and readiness-focused strategy to help ensure that our servicemembers and their families get the care they need, when they need it, and in the venue most appropriate and convenient to get and keep them healthy. I continue to reinforce this point within Navy Medicine: In order to be the provider of choice for our beneficiaries and provide that strong clinical experience to prepare our staff for the next deployment, we must use every opportunity to enhance patient experience and breakdown any barriers to convenient, patient-centered care. Much is said about the potential burden of our patients in navigating the health care system. We take seriously the trust placed in our hands to provide them the best care possible. A significant part of that is being their advocate in that system. We do that best when they

are enrolled to us and we have both the visibility and responsibility for their care in our facilities. We are working hard to improve that care through our collective efforts in building the MHS into a high reliability organization (HRO).

In delivering trusted care to our patients, we must never lose sight that the most important component of Navy Medicine is our people. We have 63,000 officers, enlisted personnel, government civilians and contractors serving around the world delivering outstanding care and support services to sailors, marines, and their families. Our commitment to them is to ensure that they will be well-trained and ready to meet their responsibilities of protecting and preserving the health of those entrusted to their care, at home and deployed.

WAY FORWARD

Our sailors and marines know that Military Service can be professionally rewarding, physically demanding, and potentially dangerous. They and their families expect us to protect their health, prevent injury and disease as best we can, and heal them when they're wounded or injured. Equally important, they want that same support for their families by having access to high quality health care when they are deployed and at home. In addition, our retirees and their families, through service and sacrifice, have earned a health care benefit that is both comprehensive and affordable. A strong and vibrant direct care system allows us to do those things while providing that exceptional clinical experience for our staff, from sickbay to medical center, augmented by vibrant R&D and top quality education and training so that we can ensure we will have done all we can to save lives on the battlefield and return home safely America's sons and daughters.

To this end, I believe that any health reform efforts must maintain the direct care system as the strong epicenter of the MHS. Our MTFs directly support the training, readiness, and sustainment of the men and women of Navy Medicine so they can continue to do what they have done since the founding of our Navy: Save lives when it matters most and provide the best care possible to those who have volunteered to defend our freedom. Any potential TRICARE reforms must contribute to this vital responsibility by leveraging the strength and talents of our medical forces and our MTFs, helping us embrace the rapid transformation underway in health care and accommodate the changing preferences of our patients and our force in how they seek healthcare. These factors present great opportunities for us as we aggressively implement best practices and scalable solutions throughout the MHS and build upon productive collaborative relationships with leading health system and academic medical centers. We continue to make solid progress but all of us recognize the formidable work ahead. We thank you for your leadership and look forward to working with this Committee in this important work.

Senator GILLIBRAND [presiding]. Thank you all. I am very grateful for your testimony. I am very grateful for your service, and I appreciate this discussion today.

I would like to start with Dr. Woodson. Senator Tillis and I are both very interested in this issue of comprehensive autism care. I am pleased that the Defense Agency initiated the comprehensive autism care demonstration in 2014, and I am very interested in seeing the outcomes of this program.

However, I am concerned to hear that DHA [Defense Health Agency] intends to lower reimbursement rates for providers of ABA therapy for autism. I am most concerned that providers of ABA therapy will no longer be able to accept TRICARE because the reimbursement rates are too low.

Are you at all concerned about the impact changing reimbursement rates will have on children's access to ABA therapy, and what steps have you taken to ensure that access to these services will not be adversely affected by changes in reimbursement rates?

Finally, why not wait until the demonstration program is complete so that the results are not skewed by a rate change?

Dr. WOODSON. Senator, thank you for that very important question, and let me just assure you that I am, as we all are, very com-

mitted to special needs children. That has been a major emphasis in terms of many of our reform activities.

In regards to the rate changes, the rate changes were actually delayed a year and a half. We did an internal study on rates because there were no established national rates, and of course, part of our statutes require us to pay Medicare rates. We set an amount and we studied it for a few years, did an internal review. Then we were about to make rate changes, and in fact, we heard from stakeholder groups, including Autism Speaks and others, convened repetitive conferences to engage them, and then commissioned two outside studies that confirmed that we were overpaying. I would be happy to share the details of these studies with you.

Finally, just to ensure that in fact we will not negatively impact the services, we reviewed network adequacy almost on a monthly basis and certainly very frequently. We will be monitoring the situation very closely. Should we find, in fact, in any locality that it has been adversely affected, we will make rapid changes.

The final point in regards to this is that we put in a safety valve in that we are not going to reduce rates right away completely. It is a stepwise progression over a number of years so that we can ensure that we do not lose providers.

Senator GILLIBRAND. Well, I have some specific concerns with regard to the studies and the methodologies because I do not think they are reflective of the cost. I would like to request some follow-up information specifically on that and further consideration because I think it is inadequate. The reason why Autism Speaks spoke so forcefully against the proposed rate changes is because they are the experts on treating children with autism. I think your study is misleading in its outcome. I will follow up with specific questions, but I would like this to be readdressed because I am very concerned that there will be very negative consequences for patients.

My second question is about innovation and different ideas about how to innovate health care for our servicemembers. When I was in Fort Drum earlier this month in upstate New York, I was impressed with their approach to health care. There they have a clinic on the base that provides basic primary care and service to members and their families—for their members. Their members and families also go off base for their specialty care. The clinics and providers in the community, by virtue of serving the military population, have an excellent understanding of the needs of our men and women in uniform and their families. This is along the lines of questions that Senator McCain asked to the last panel.

Has DHA looked to Fort Drum as a model for providing health care, and how can we better leverage community health care options in serving the military community? Anyone can take the question.

VADM FAISON. Senator, I will share with you a pilot we have in San Diego right now. In San Diego County, one out of every five residents is eligible for military health care. That is 250,000 people. Of those, 662 are what we call high utilizers. These are folks that use anywhere from 15 to 30 times as much health care as anyone else in the county.

We have partnered with county public health to aggressively manage them as a community-based effort. These are folks that the car will break down and so they will call 911 to get a ride to the ER to get medications. Care will be fragmented in a variety of different urgent care centers. By partnering with county public health and bringing to bear county services, as well as military provider services in a medical home approach, but in a community-based format, we have improved their health, cut their health care costs in the first year for 250 of them by over \$4 million, in the second year, by \$12 million, and dramatically cut by over 60 percent their hospitalizations. That is one issue that we are in the process of exporting across Navy medicine.

Senator GILLIBRAND. Thank you.

LTG WEST. Thank you, Senator Gillibrand.

Regarding the innovation of health care in the Fort Drum model, that is a phenomenal model for that area. We have noticed that it might not fit in all of our demographic areas. The sizes of our MTFs vary from location to location, and that may not be reproducible.

There are additional things that we are doing such as at Fort Leonard Wood, Missouri, the innovation of using telehealth where they actually have a virtual ICU [Intensive Care Unit] set up where they have a telehealth arrangement with an ICU in the State of Arkansas to help them with that. These are leveraging technology using telehealth, using other types of partnerships in order to achieve some of those same ends.

I agree that for the Fort Drum community, that model that they have works very well.

Lt. Gen. EDIGER. Senator, I mentioned in my statement that the Air Force has 13 hospitals. That is actually below our operational requirement for deployable medical teams. We have had to use some innovative concepts in order to meet our operational requirements. We have about 2,500 Air Force medical personnel embedded in other services' hospitals, and that is one way we are doing this.

The other way we are doing it is we have embedded surgical staff into private sector hospitals in Omaha, Nebraska; Tampa, Florida; Phoenix, Arizona; Oklahoma City; and in Birmingham, Alabama. They are providing beneficiary care in those hospitals.

I would say, though, that while that model has been successful for us to some extent, I do not think we can go too heavily in that direction because, as I said in my statement, the military hospital remains the bedrock of our readiness because that provides readiness to the entire deployable team, the enlisted, the nursing staff. The embedded operations in private sector platforms tends to benefit the provider staff but not so much the nursing staff.

VADM BONO. Ma'am, there are some other areas too where we have all been doing some innovative work, and this is in our enhanced multi-service markets. Each of the services has this where we have about 45 percent of our resources and 45 percent of our patients where they need care. What is innovative about that is that between the services, we are able to level-set some of our resources, and depending on where the demand is for care, one of the hospitals can send personnel to other hospitals within that same market where the demand is.

Just as an example, here in the National Capital Region, when we were looking at the demand for physical therapy services, we were able to understand with a baseline assessment of where the demand for physical therapy consults were coming from, referrals. By using some of the assets within a couple of the bedded facilities, we were able to send physical therapists to those clinics where there was a high referral rate. By doing that, we were able to get care closer to the patient in a more timely manner, and it also decreased some of the demand for specialty care down the road. This is something that all of the services have with the enhanced multi-service markets.

Senator GILLIBRAND. Thank you very much.

Senator GRAHAM [presiding]. Senator Tillis?

Senator TILLIS. Thank you, Mr. Chair.

Mr. Woodson, rather than go back through what Senator Gillibrand brought up on the ABA treatment, I would like to join with Senator Gillibrand in some follow-up.

I think the key there has to do with timing, and the most important thing is to understand the profoundly important value of this treatment for not only the child that may be receiving the treatment, but also the health and quality of life for the Active Duty personnel, the military personnel, and the spouses.

Admiral Faison, I want to start with you and then probably ask the other Surgeons General to chime in because I think you are making a very important point about the unique nature of this health system. I also want to get to military hospitals, clinics produce inpatient, outpatient workload costs about 50 percent higher than what it would cost if the services were purchased in the private sector.

Can you give me some help in trying to rationalize what the real gap is? Because there is obviously some structural cost based on the unique nature of what you are doing. Give me some sort of sense of what you believe may be an attainable goal or some sort of narrowing of the gap. Or is that gap right and proper?

VADM FAISON. Yes, sir, absolutely. If you look at our costs, our costs break down really into two large buckets. There are smaller buckets, but the two large buckets, of course, are facility costs of maintaining bedded facilities. Those are important as we get casualties back, the Walter Reeds of the world and places like that—

Senator TILLIS. There is an unused capacity that you may not find in comparable private health care settings.

VADM FAISON. Absolutely. If you look at the civilian sector, they are running bed occupancies of 90-plus percent. We do not do that because our beds are in reserve for contingency operations.

The others are personnel costs. We staff to operational plans of the combatant commanders. I do not staff to peacetime care. I have in some places more staff in uniform than necessary for peacetime demand, but that is because there is an operational war requirement. We try and put those personnel in places where can keep their skills current. As you have heard, sir, from the other Surgeons General, when we cannot do that, then we do out-service rotations at civilian centers and places like that.

Senator TILLIS. I am sorry to cut you off. I have just got a couple of questions. I want to make sure I get at least one more.

Is there a good sort of breakdown or something that you all can provide us that really gives that to us in an empirical way? Because if we make decisions about going back and saying that we have narrowed the gap, that it is no longer 50 percent, if that is the right number, then we have to understand the tradeoffs that we have in terms of capacity and what you are preparing to deal with. I think that that would be very helpful to get back to this committee as we go through and identify maybe opportunities. You in your opening statement said you are not perfect. I want to go find out where those imperfections are and spend the bulk of our time on this committee fixing those rather than going down a path where if we look at the data, we may agree that it is a structural cost that is the cost of doing business and the unique nature of your business.

[The information referred to follows:]

VADM FAISON. As I mentioned in my opening remarks, no health care plan in the world puts their lives on the line in battle to defend and care for their patients. It is not possible to accurately compare the Direct Care system to care delivered in the private sector. Navy Medicine is a rapidly deployable, fully integrated medical system and this is what sets us apart from civilian medicine. We are the last country in the world to have this capability. Our direct care system serves as the readiness platform for our providers and is critical to sustaining the vital skills and clinical competencies for our medical force.

The range of costs for the same surgical procedure in the private sector can vary widely, making it difficult to equate to procedures performed in the direct care system. For example, in the Federal Health Care Benefit, Blue Cross costs more than Kaiser Permanente—an HMO. HMOs such as Kaiser control costs using limited choice in doctors, specialists, high co-pays and limits on access to care. We do not use these same tools in order to ensure choice, provide high quality care, and maximize access for our Active Duty servicemembers, retirees, and dependents as part of the TRICARE benefit.

Additionally, Direct Care costs include the cost of readiness. We understand there is a desire to separate out these costs, and we are working towards a solution. Our goal in Navy Medicine is to provide exceptional value to those we serve by ensuring superior health outcomes through the safest and highest quality care, convenient access, full and efficient utilization of our services, and lower care costs.

General, did you have a comment?

Lt. Gen. EDIGER. Yes, sir.

I think one thing that is always a challenge, when you talk about differentiating the cost of readiness versus the cost of providing care, is as I said in my statement, the two are really inextricably intertwined. There is a lot of work we do that is operationally driven that is actually clinical in nature. If you look at our primary care operations, for example, things like medical evaluation boards, annual preventive health assessments, post-deployment health assessments, all of these things consume a significant amount of our primary care bandwidth. It is very challenging to try to look at perhaps the cost of providing care to enrollees to our clinics and cleanly cleave and separate the cost of readiness versus just the cost of providing care. That is one of the traditional challenges we have always had with answering this sort of question is that the two really are intertwined very significantly.

Senator TILLIS. Yes. I think the key is to try and normalize it in some way that people can understand it, again so that we set the priority on the things that we should improve rather than look

at things from a purely numerical basis that on the surface may look like an opportunity to drive improvement, but the consequences could be just the opposite of what we want to accomplish on this committee, which is to work with you and improve.

Mr. Woodson, the TRICARE legislative proposal did not contain, I do not believe, any recommended improvements for Guard and Reserve communities. What is in the offing there? What can we expect?

Dr. WOODSON. Thank you very much for that question because that set of proposals really requires some additional studies because I think there are several courses of action depending on what type of reservist we are talking about. Let me just give you some examples to crystallize.

On the one hand, of course, we initiated TRICARE Reserve Select to fill the gap in what we thought was medical readiness at the height of the war. The consequence of that was that the reservist and family would have to switch insurance programs when they came on Active Duty.

There is the possibility, frankly, of offering, of course, TRICARE Reserve Select to a larger population or including it in employer-based options, which might be reasonable.

There is the possibility, as the commission talked about, of providing a basic allowance for health coverage when they come on Active Duty, and we need to sort that out.

Then there are some other hybrid options that are out there.

The issue with reservists is really about not forcing them to change providers when they come on Active Duty. There are different solutions, and we need to work those out and study those a little bit more.

Senator TILLIS. Thank you.

Thank you, Mr. Chair.

Senator GRAHAM. Senator Blumenthal?

Senator BLUMENTHAL. Thanks, Mr. Chair.

As you may recall, Dr. Woodson and other members of the panel, in the 2016 National Defense Authorization Act, I advocated for a uniform formulary for improved transition from DOD care to the VA as servicemembers transition out of Active service. This measure was successfully passed, and now we are in an implementation stage. This joint formulary I think is critical to the quality of care and, in fact, relates to a variety of related medical issues that may arise when there is a lack of sufficient transition in prescription drugs and other health care.

What is the status of the implementation of the joint formulary from the DOD perspective?

Dr. WOODSON. I think there has been much progress certainly in the areas of mental health medications, pain medications, and some of those other critical medications for conditions in which a gap would create a great deal of problems. They have been mapped significantly to about the 96 percent level so that we have a single formulary. I know there is just a little bit more work that needs to be done on that, but there has been significant progress on that front.

Senator BLUMENTHAL. On the issue of prescription drugs, particularly pain killers and opioids, is there an ongoing danger in the

military as, frankly, there is in the civilian world of over-prescription and over-reliance on pain killers?

Dr. WOODSON. Well, there is. That is something that needs to be addressed not only nationally but within the military health system.

What I would say is I think in that regard, we are a little bit ahead of the curve and the reason being is that for a lot of different reasons, there has been a lot of focus on the use of pain medication. We have developed more comprehensive strategies in terms of clinical practice guidelines. We have courses that providers must take in terms of pain management. We have invested in research and integration of alternative methods for pain control. This has been part of a comprehensive set of programs I think that we could even make available to some civilian health care systems.

Senator BLUMENTHAL. On the issue of mental health care, has there been progress there, do you think?

Dr. WOODSON. I think there has been progress, but you know, mental health care—the more we study it, the more we try and refine it, the more we find out about it. If I could break this down into a couple of different issues.

Oftentimes dealing with mental health care, it is more than just delivering mental health care. It is about delivering social services and family supports, and that is one issue.

The other issue about mental health care is that we always have this issue about whether or not we have enough providers, but really what we need is a comprehensive new strategy for how we employ our mental health specialists in a rational way to deliver care. We never will have enough psychiatrists. We will never have enough pediatric psychiatrists. If we utilize them to do screening, then we make their time less available for treating complex problems. What we need to do right now is work on a more rational approach to how we employ, let us say, certified mental health counselors, psychologists, licensed psychological nurses, licensed social workers in a continuum of care that allows us to address all the needs more comprehensively because I am not sure we will ever generate enough mental health providers.

Senator BLUMENTHAL. That is the strategy that you say has to be developed or is being developed?

Dr. WOODSON. I think we are working on that. The previous panel talked about the issue of embedding mental health care in primary care practices. We have been doing that for years. We have been embedding mental health care technicians and practitioners in line units. We have already rolled out some of that more comprehensive strategy, but still, I think we need to array the different types of mental health professionals in a better way to take care of many different problems.

Senator BLUMENTHAL. As you know, Active Duty members of the military who may suffer emotional or mental diseases, some of them emanating from combat, post-traumatic stress and traumatic brain injury, sometimes are given bad conduct discharges or less than honorable discharges, bad paper, and then through a tragic irony are deprived of medical care to treat the very injury that causes their discharge under less than honorable conditions. I have sought to have those discharges reviewed. In fact, two Secretaries

of Defense, beginning with Chuck Hagel and most recently Ash Carter, have committed to change the policies of the boards of correction review within each of the services.

Has your input been sought on that issue? Because there are medical issues involved in those reviews.

Dr. WOODSON. The short answer, Senator, is yes. Let me, first of all, thank you for your advocacy in this area. Of course, for the last 2 years, we have actually reached out to individuals who have been discharged with so-called bad paper to let them know that their cases will be reviewed.

To the last part of your question, we have given mental health professionals to these boards of review so that the cases can be accurately reviewed.

Senator BLUMENTHAL. Thank you. My time has expired.

These subjects are tremendously important, and I want to thank all of the panel members for your hard work, all of the hard work done by the men and women under your commands. Thank you for being here today.

Senator GRAHAM. Thank you.

I will be, it looks like, the last questioner here.

How many casualties have we suffered in Iraq and Afghanistan? Not fatalities but injuries. How many people have been wounded requiring admission to a hospital? Does anybody know?

Dr. WOODSON. Senator, it depends on how you actually calculate those numbers, whether or not you include disease and non-battle—

Senator GRAHAM. It does not matter as long as you were in Iraq and Afghanistan.

Dr. WOODSON. It is over 100,000.

Senator GRAHAM. Admiral Faison, can you imagine a military health care system that did not have a military hospital?

VADM FAISON. Sir, no, I cannot.

Senator GRAHAM. Okay, because the bed space you have is not designed for everyday activity. It is designed for wartime contingencies. Is that right?

VADM FAISON. That is correct.

Senator GRAHAM. Most of these beds are empty during peacetime simply because they are built to deal with wartime contingencies.

VADM FAISON. Sir, if I may. Those beds are not empty. We work very closely with the managed care support contractor to get care back into our facilities—

Senator GRAHAM. What percentage of your beds are occupied—

VADM FAISON. In general, we try and maintain a bed occupancy of 80 percent or higher.

Senator GRAHAM. What about the Air Force?

Lt. Gen. EDIGER. Sir, we have a lower bed occupancy than that. We are more in the 50, sometimes up to 70 percent range.

Senator GRAHAM. What about the Army?

LTG WEST. Sir, it varies. Some of our large MTFs, Fort Bragg and San Antonio, have a higher occupancy rate. Some of our smaller facilities have a low daily patient census, and those are the ones that we are actually looking at to realign capability there.

Senator GRAHAM. Here is my point. If we are going to reform something, we need to understand what we are trying to accom-

plish here. If you had civilian hospital administrators over military medical facilities, would that create a problem?

VADM FAISON. Sir, military hospitals are just like any other military command. I personally would not put a civilian in charge of a ship.

Senator GRAHAM. That is what you would be doing, would it not?

VADM FAISON. Exactly. Yes, sir.

Senator GRAHAM. A hospital is a military entity, and the military command structure cannot be substituted.

VADM FAISON. Yes, sir, because the good order and discipline carries over to the battlefield and it starts in the hospital.

Senator GRAHAM. General West, at the end of the day, what would happen if we opened up competition to all these military facilities? Where would the military doc go?

LTG WEST. Sir, that is a very good question.

Senator GRAHAM. What would they do?

LTG WEST. Sir, again——

Senator GRAHAM. Like a dentist. Like if it is cheaper to pull teeth downtown, which it may be, like how do our dentists stay proficient in pulling teeth?

LTG WEST. Yes, sir, exactly. When you say open to competition, sir, I think we are not in the same business as for profit. No one appears they want to be in competition for our deployed environment.

Senator GRAHAM. You treat family members of Active Duty personnel, all of you. Right?

LTG WEST. Yes, sir.

Senator GRAHAM. That keeps your skill level up. It is good for retention, good for recruitment.

LTG WEST. Yes, Senator.

Senator GRAHAM. Does every member of the military have to through an annual physical? The answer is yes.

VADM FAISON. Yes, sir.

Senator GRAHAM. Is that not primary care, General Ediger?

Lt. Gen. EDIGER. Yes, sir.

Senator GRAHAM. That is a primary care activity that is related to readiness.

Lt. Gen. EDIGER. Yes, sir.

Senator GRAHAM. Those same doctors will be treating kids with a cold.

Lt. Gen. EDIGER. Yes, sir.

I would add that what we do when we provide care in our MTFs, we are ultimately a mission support activity. We are actually supporting commanders who are conducting missions. In the Air Force, it is global mobility. It is the nuclear mission on its RPA [Remotely Piloted Aircraft] operations, cyber ops. By taking care of the airman and the family in our military treatment facility, we are actually helping that commander take care of that family.

Senator GRAHAM. When you say that a military hospital costs 50 percent more to operate than a civilian counterpart, is that a fair comparison, given the unique nature of military medicine?

Lt. Gen. EDIGER. I think it is an apples and oranges kind of comparison, sir, because——

Senator GRAHAM. You agree with me you could make things more efficient.

Lt. Gen. EDIGER. Absolutely.

Senator GRAHAM. That is the goal. Right?

Lt. Gen. EDIGER. Yes, sir.

Senator GRAHAM. Do you all agree with me that the people under your command have done historic work on behalf of the Nation?

VADM FAISON. Absolutely.

Senator GRAHAM. I want to tell everybody on this committee, that in this war, which has been going on for 14 years now, there are people alive today that would not be alive in any other war, and you guys are the unsung heroes of this war, as far as I am concerned. I have been to forward-deployed areas where people come in who have been blown up, and it is amazing how you can put people back together again. That whole network from Landstuhl to Walter Reed is just literally priceless, but it needs to be more efficient.

Any last comments?

Dr. WOODSON. Senator, if I may make one comment in connection with making sure everyone understands that the maintenance of a military health system is essential to the defense of this Nation. The point I would make and give you an example is that the MTFs are part of the medical force-generating platform. Today in this country, there are 1,000 fewer graduate medical education spots than there are American medical graduates. If we were to eliminate the military treatment facilities and the military health system, we could not generate enough doctors—and I would say also nurses, but doctors to come on Active Duty. There just are not enough training slots in this country. We must preserve this generating platform and we must preserve the graduate medical education program.

Senator GRAHAM. On not a happy note, I think TRICARE, as it is designed, is really antiquated. I would not give it a B. I am really going to be hard on your guys to come up with reforms, not just premium increases. We are going to look at TRICARE and turn it upside down and make it more transparent and make it more accountable because we are basically using civilian networks when it comes to retirees and their families.

With that said, this has been a great hearing. Thank you all for your service, and we will stay in touch.

The hearing is adjourned.

[Whereupon, at 4:24 p.m., the committee was adjourned.]

[Questions for the record with answers supplied follow:]

QUESTIONS SUBMITTED BY SENATOR LINDSEY GRAHAM

GUARD/RESERVE HEALTHCARE

1. Senator GRAHAM. Dr. Woodson, DOD's TRICARE legislative proposal contained nothing of substance to improve healthcare delivery for the Guard and Reserve communities. At the hearing, you mentioned that the Department is exploring its options for the Guard and Reserve community. What options are you considering to improve the TRICARE Reserve Select program for Guard and Reserve members and their families?

Dr. WOODSON. First, we believe that TRICARE Reserve Select (TRS) will be improved by instituting TRICARE Choice. Guard/Reservists will pay the same 28 percent that they do now but get a more modern PPO like benefit with fixed network

copays without paying a deductible. Second, DOD has made a separate legislative proposal that would require that Medicare participating physicians and other providers also participate in TRICARE and the Veterans Choice program. This directly addresses the issue of reserve family TRICARE beneficiaries having to change doctors when the member is called for extended Active Duty by strengthening the network of participating providers in all communities throughout the United States. Third, while most physicians already accept TRICARE, for those in areas with few TRICARE beneficiaries (as is true for many areas where reserve families live), we can use current authority to pay up to 115 percent of the normal rate for families of reservists called to Active Duty in support of a contingency operation. Fourth, we need a better understanding of the real issues involved in the transition of reserve family members from employer-sponsored coverage to TRICARE when the member is called to Active Duty. We need to supplement the scattered anecdotal reports of beneficiaries needing to change doctors with specific information on the circumstances of any transition problems so that we can develop appropriate solutions. Finally, we have conceptualized other possible approaches, such as: a Basic Allowance for Health Care (BAHC) for families of activated Guard/Reserves; options to make TRICARE Reserve Select more attractive; a plan similar to the Federal Employees Health Benefit Program; and a way to coordinate health coverage between employers and DOD for reserve component families. However, these possible options require more analysis, and perhaps limited pilot tests, to determine: 1) if they would actually solve documented problems; 2) their feasibility and cost; and 3) unforeseen second and third order consequences.

2. Senator GRAHAM. Dr. Woodson, what is your timeline for making a decision on which options to implement?

Dr. WOODSON. Step one is to get a better understanding of the specific friction points associated with the transition of reserve component family members from employer sponsored care to TRICARE when the member is called to extended Active Duty. This will ensure that we are developing solutions to actual problems, rather than perceptions and anecdotes. We will be studying the issue over the next several months and will propose potential solutions within one year. We expect that DOD would be able to present our findings and proposals during the first session of the next Congress.

TRICARE REFORM

3. Senator GRAHAM. Dr. Woodson, VADM Bono, Lt. Gen. Ediger, LTG West and VADM Faison, DOD's TRICARE legislative proposal for fiscal year 2017 would encourage beneficiaries, through targeted fee increases, to get the majority of their care in military hospitals and clinics. With DOD's proposal, the Department asks beneficiaries to trust that you will transform the direct care system into a high-performing health system. For many years, we have heard DOD and the Services make promises to improve the delivery of healthcare for beneficiaries, but little progress has been made. Why should beneficiaries trust DOD and the Services to deliver on your current promises?

Dr. WOODSON. and VADM BONO. For one thing, DOD is implementing the very meaningful reforms that were included in the National Defense Authorization Act for Fiscal Year 2016, including requirements to ensure that access standards are met, implementation of the urgent care pilot, and much greater transparency in performance data on access, quality, patient safety, and beneficiary satisfaction. These and other actions lay the foundation for future improvements in care delivered through the MHS.

In the near term, all of the Services are focusing on improving access and quality of care. Medical Home initiatives are being expanded and further supported, improving beneficiary access to comprehensive medical care. Roll-out of the Nurse Advice Line and secure messaging initiatives offer to increase beneficiary access to professional medical advice. Efforts to streamline the referral process are designed to lessen irritation. Telehealth capabilities are being expanded and enhanced right now. The Services are also implementing programs to improve Active Duty wellness and enhance behavioral health.

Other actions are laying the groundwork for continued future improvement. Access measures have been added to the enterprise-wide dashboard, and are reviewed by senior leadership monthly. MHS is rolling out standard quality and safety measures across the enterprise to allow leadership to compare performance across MTFs. MHS is expanding participation in the American College of Surgeons National Surgical Quality Improvement Program (NSQIP), which provides a comprehensive suite of measures of the quality of surgical care. Enhanced measurement means problems

are identified and corrected, and this sets the stage for improving trends in quality of care provided.

In addition to these administrative improvements and the legislation to reform the TRICARE health plans, DOD's other health program legislative proposals are also part of a comprehensive Military Health System reform package. These include requiring Medicare participating providers to also participate in TRICARE and the Veterans Choice program. This will strengthen TRICARE networks of participating providers throughout the United States. We have also proposed enhanced preventive care services and an improved program of dental and vision coverage.

We believe enactment of our package of legislative proposals and Active oversight of our continuing implementation of administrative reforms are the ways Congress can ensure that we deliver on real Military Health System reform.

Lt. Gen. EDIGER. The Air Force has improved access to care across our system by 20 percent over the past 18 months and continued improvement remains a top priority. We overhauled Air Force primary care in 2008 under the Patient Centered Medical Home model, which generated team-based care and improved performance against national averages in preventive care and care for chronic disease. Under this construct, team continuity of care is consistently above 90 percent across our system and patient satisfaction has risen above 90 percent.

Our strategy for continued progress in improving access to care by enabling more same-day access, includes actions pertaining to filling of primary care provider positions, improved temporary fills of provider positions gapped due to deployments and standardization of management practices within the clinics. As our primary care teams are primarily staffed by Active Duty, access is negatively impacted each year by staff transitions due to reassignment, deployments and separations. In fact, such gaps are our top challenge in regard to access to care and would be alleviated with a staff mix with a higher proportion of civilian positions. Relief from the 2009 NDAA restriction on mil-to-civ conversions in the medical services would give the Air Force the flexibility to change the staffing mix in a way that would significantly improve access to care. As a measure to provide some degree of relief, the Air Force is in the process of seeking resources to add some civilian primary care positions to enable improved coverage of gaps in Active Duty fills.

Additionally, the Air Force has implemented policies for first call resolution to patients; increase same day appointment availability; eliminate referrals for physical therapy; streamline the specialty care referral process; and implemented the FY16 NDAA urgent care pilot. The pilot allows Active Duty servicemembers (ADSMs) in TRICARE Prime Remote, non-ADSMs in TRICARE Prime, TRICARE Prime Remote, or TRICARE Young Adult, and TRICARE Overseas Program beneficiaries traveling in the U.S. to seek two urgent care visits each fiscal year without a referral or prior authorization. Jointly with the Army and Navy, we have developed a Military Health System Specialty Care Referral Accountability and Business Rules policy that will compress the timeline from referral order to specialty care appointment. The objective of the new policy is to make the referral management process more patient-centered by increasing uniformity, reducing wait times before appointment booking, and improving central accountability for referral management performance.

LTG WEST. Army Medicine has made great strides towards transforming the direct care system to meet the needs of our beneficiaries particularly with access to primary and behavioral health care. We have significantly increased the annual number of primary care appointments for all patient beneficiary categories in our Medical Treatment Facilities (MTF) while concurrently increasing patient satisfaction with access to care. We have further increased primary care appointment capacity and convenience with our 20 Community Based Medical Homes and have immediate plans to add 4 more before the end of FY17. The number of behavioral health providers has more than doubled since 2007 and many are located in small clinics located near where soldiers live and work.

Army Medicine has completely transformed its system for delivering behavioral health care in the last five years and now offers services that exceed the standard of care delivered in the private sector. The implementation of the Primary Care Behavioral Health team complements the efficiency of managing non-acute behavioral health concerns without a referral at the Army Medical Home appointment to foster an improved patient experience and improved satisfaction. MEDCOM has developed the nation's leading system for collecting and using clinical outcome data in the field of behavioral health. The Behavioral Health Data Portal, providing standardized information on patient's progress in treatment, has been used in over 2.2 million clinical encounters. Additionally, MEDCOM has established the Child and Family Behavioral Health System (CAFBHS) on all Army installations blending best practices in consultation, collaboration and integration of care to meet the needs of Army

Children and Families in support of the Patient Centered Medical Home. CAFBHS includes School Behavioral Health, now present in 60 schools across 14 installations, which places behavioral health providers in clinics within schools on Army installations.

We continually focus on improving quality care and satisfaction for our female beneficiaries. Army Medicine has numerous quality measures which exceed the national perinatal average, such as: 1) Percent of Cesarean Deliveries is 23.9 percent in the Army (31 percent for the national average); 2) Primary Cesarean Delivery rate is 12.60 percent in the Army (17.53 percent for the national average); 3) Neonatal Mortality is 0.06 percent in the Army (0.24 percent for the national average); 4) Vaginal Deliveries with coded Shoulder Dystocia linked to Birth Trauma is 12.62 percent in the Army (13.75 percent for the national average); and 5) Postpartum Hemorrhage is 2.88 percent in the Army (3.69 percent for the national average). In addition, obstetric patient satisfaction, as measured from the TRICARE Inpatient Satisfaction Survey, continued to increase over the last year from 55.3 percent to 64.5 percent in 3rd quarter of FY16. The Women's Health Service Line is invested in providing an outstanding patient experience for our beneficiaries and shares best practices across the enterprise in order to sustain improvements and continue increasing patient satisfaction.

In addition to providing care during normal duty hours using traditional methods, Army Medicine actively promotes virtual health care, leverages technology, and provides extended care hours as medical force extenders. Army Tele-health and Tele-Behavioral Health provide clinical services across 18 time zones in over 30 countries and territories across all Regional Health Commands and in the deployed environment. Working together, TRICARE Online, the Nurse Advice Line and Army Medicine Secure Messaging improve access for our beneficiaries. TRICARE Online is used to schedule or cancel appointments, the Nurse Advice Line provides high-quality and safe professional medical advice to our beneficiaries 24 hours a day and Secure Messaging provides a confidential means of communication between beneficiaries and providers. Finally, many Army treatment facilities offer appointments after 1600 hours or on the weekends and have either an Acute Care Center (ACC) or a "fast track" clinic inside their Emergency Rooms.

In April 2016, Army Medicine modified the first call resolution policy to ensure that 100 percent of enrolled beneficiaries receive an appointment at the time of the initial request. If an appointment is not available in the direct care system within the access to care standards, the call center clerk will offer the beneficiary the opportunity to be seen in a network ACC and will help the beneficiary find the nearest network ACC. Based on current survey methodology, MEDCOM's overall satisfaction with the phone appointing system service is now the highest it has been in over six years.

Additionally, only 12.3 percent of U.S. hospitals participate in the American College of Surgeons sponsored National Surgical Quality Improvement Program (NSQIP), a voluntary risk-adjusted performance metric data collection. Army Medicine began submitting information to NSQIP about eight years ago for our eight largest hospitals. We are now submitting data for 17 of our 19 Army bedded hospitals. Overall, Army MTF performance for surgical quality is comparable with NSQIP participating civilian hospitals. In a review of quality of care issues related to patient volume, our outcomes were equal to or better than our civilian counterparts. We continue to strive for excellence in quality of surgical outcomes. All of the established NSQIP sites are active in the MHS Strategic Partnership with the American College of Surgeons, which is dedicated to surgical quality and provides opportunities for engaging in quality improvement initiatives.

Army Medicine remains committed to meeting the needs of all our beneficiaries. Our significant gains in access and satisfaction provide a history of success. With continued focus and dedication, we will ensure beneficiary trust is rewarded with efficient, safe, and quality healthcare.

VADM FAISON. Navy Medicine understands that it is a privilege and honor to have the trust of our beneficiaries. We have made significant improvements in the way we deliver health care as a High Reliability Organization (HRO). We are committed to offering the best patient centered care the nation has to offer through innovative partnerships, access built around our patient's needs, the latest in virtual health and technology, and innovative treatments that impact health outcomes and the experience of care.

Since the Military Health System (MHS) review in 2014, we have worked diligently across the enterprise to further enhance and build on efforts in the areas of access, safety and quality. As reported in the MHS Review, DoD Medical Treatment Facilities (MTF) were found to be "as good or better" than many top tier civilian institutions nationwide. As an HRO, we have centered our efforts on further opti-

mizing clinical outcomes, enhancing access, leveraging technology, enhancing the coordination of care, and achieving zero patient harm. A critical component of the HRO Operating Model is the Clinical Community Structure. Navy Medicine has established the role of Chief Medical Officer (CMO) throughout the enterprise with the responsibility to engage clinical leadership and promote transparency. Together these efforts build on past successes to shape a systemic culture with focus on safety and quality health care.

We continue to search for innovative solutions to best serve our beneficiaries while maintaining the highest level of readiness for the next conflict. Primary care and many self-referral appointments are now available for on-line booking to ease the process for our patients. We also implemented a population health portal which provides a more holistic approach to our patient's health care needs. As part of a Tri-Service initiative, Navy Medicine has launched a "PCM On-Call" pilot, where we are connecting patients to providers after hours by offering the option to speak with MTF-based clinicians.

As a result of some of the initial improvements in readiness and health outcomes, we have expanded the Medical Home Program to 23 Marine-Centered Medical Home and 5 Fleet-Centered Medical Homes to enhance access and care for our operational forces. We will also continue to invest in our robust secure messaging program, Tricare Online, and Nurse Advice Line to maximize access and convenience for our patients. For example and emulating goals from the civilian sector, we have set and are currently exceeding our goal of ensuring at least 80 percent of secure messages are answered within one business day.

Our Value Based Care Pilot at Naval Hospital Jacksonville focuses health care delivery on improved patient outcomes, increased readiness, higher patient satisfaction, and improved value with optimal resource utilization. To understand the patient's experience, we are using the Joint Outpatient Experience Survey to assess the patient experience with care received at Navy Medical Treatment Facilities and across all of the Services. Moreover, we are steadfast in recruiting and training aspiring health care professionals that will continue the long tradition of providing safe, efficient, and quality health care to the warfighters and their families.

Navy Medicine is also leveraging technology to improve access and convenience for all beneficiaries. We continue to expand our web presence and implement telehealth options wherever feasible to ensure our patients have timely access to care. In addition, BUMED is developing an enterprise mobile application, based upon an extremely successful model utilized at Naval Hospital Camp Lejeune, where patients can easily view available appointments, pharmacy wait times, and access important facility information. Our dedication to technology helps ensure Navy Medicine remains viable in an extremely complex and dynamic health care environment.

ACCESS TO CARE

4. Senator GRAHAM. VADM Bono, Lt. Gen. Ediger, LTG West and VADM Faison, instead of the current disjointed processes in place today, should the Defense Health Agency (DHA) and the Services implement a centralized, standardized medical appointment system with expanded appointment availability across military hospitals and clinics to improve access to care?

VADM BONO. The Services and the DHA have implemented a centralized, standardized medical appointment system called the Composite Health Care System (CHCS). CHCS is the sole appointing system used by the military medical treatment facilities (MTFs) to schedule appointments. Appointment data from CHCS is transparent in the TRICARE Operations Center.

Primary Care appointing processes are standardized across the Services and the DHA, regardless of whether the appointment is made by calling a centralized appointing center, the primary care clinic, on TRICARE OnLine or via secure messaging. Primary Care appointment processes were further standardized in fiscal year (FY) 2015 with two new Tri-Service policies:

- *First Call Resolution* policies outline standard Service and DHA-approved processes for use when Prime beneficiaries call the MTF for an appointment. These processes are designed to ensure the Prime beneficiaries are not asked to call back another time because no appointments are available. Currently, compliance with these policies is evaluated based on patient satisfaction with seeing a provider when needed. In addition, the Services and the DHA added a question specifically asking Prime enrollees if they were asked to call back for an appointment on the new Joint Outpatient Experience Survey (JOES); the JOES is expected to begin implementation in mid-fiscal year 2016. Finally, the Services and the DHA are modifying the CHCS appointing menu to allow measurement of how well MTFs are complying with the First Call Resolution policies.

- *Simplified Appointing* policy guidance was implemented August-October 2015; guidance standardizes requirements for primary care appointments including reducing the number of appointment types for most primary care appointments to two (24-hour and future), increasing the number of appointments available per day and maximizing the number of appointments visible to appointment clerks by minimizing “clinic book only” appointments. In January 2016, almost 99 percent of primary care appointments are 24-hour and future types, the total number of primary care appointments available per duty day increased 24 percent and almost 100 percent of primary care appointments are fully visible and available for (the <0.6 percent of exceptions includes such as vasectomies which are booked by the clinic).
- As a result of these policies and other standard Tri-Service/DHA access to care initiatives in primary care, 24-hour appointment performance improved 31 percent since the Military Health System (MHS) Review and variance among MTFs decreased 33 percent. Future appointment performance improved 20 percent since the MHS Review and variance among MTF decreased 31 percent.
- *Way Ahead:* The Services and the DHA are continuing to standardize primary care practices based on MTF leading practices validated during the summer 2015 MTF Site Visits and Patient Listening Tours by Primary Care and Access Service and DHA experts. As discussed above, the Services and the DHA have increased the total number of appointments available per duty day by 24 percent and are working to further increase the availability of appointments by extending operating hours Monday-Friday and on weekends, based on an analysis of past demand. Many MTFs have already extended duty hours Monday-Friday and on weekends, especially in Pediatrics. The Services and the DHA also are working to offer additional opportunities for care by offering virtual phone visits with primary care managers after duty hours through the Nurse Advice Line. Currently, the direct care system captures over 90 percent of its enrollees’ primary care needs; however, through the initiatives discussed above, the direct care system goal is to develop standard processes to meet an even higher percentage of its own enrollees’ primary care needs.

Specialty Care appointing is not standardized or centralized across the Services and the DHA in the same manner as primary care. The Services’ specialty clinics review the appointment requests or referrals and determine if they can provide the care within access standards. If the individual specialty care clinic can provide the appointment within access standards, some specialty clinics contact the patient directly. In other cases, the patient is directed to call the specialty clinic within three days of the Primary Care Manager referring the patient to specialty care. The Services and the DHA recognize specialty appointing processes require standardization and centralization in order to increase efficiency and to be more patient-centered. As a result, Service and DHA governance-approved new Specialty Appointing and Referral policy guidance on February 2016, which is based on some MTF and Enhanced Multi-Service Market leading practices. The Service and DHA specialty care appointing guidance is being formalized and will be implemented in fiscal year 2016. The goal of the policy guidance is to standardize and centralize specialty appointing processes to the greatest extent possible with the goal of providing the Prime enrollee with a specialty appointment date and time at the time the primary care manager recommends the care and before they depart the MTF. Finally, the Service and DHA Access Improvement Working Group is developing Specialty Care standardized appointing guidance similar to that implemented in primary care in order to increase the number of available appointments, which will facilitate centralized and standardized specialty appointing.

Lt. Gen. EDIGER. Central appointing is being utilized in some locations where more than a single military treatment facility exists. This, along with centralized referral management improves access by more completely utilizing available appointments when multiple military treatment facilities are in the same vicinity. The majority of Military Healthcare Facilities are not located within the 30 minute Primary Care Manager requirement of another military facility. We believe local management of appointment templates best enables commanders to meet the needs of the population and the mission. Local management of schedules enables template adjustments for deployment processing, exercise participation and readiness training.

LTG WEST. Centralizing medical appointing within Enhanced Multi-Service Markets is already occurring. While our focus remains on achieving efficiencies and building capacity for our enrolled beneficiaries within our MTFs, we recognize that cross-booking appointments may be a viable option for some locations. When exploring options for improving access to care we must also consider any impact on the

overall patient experience, meet expectations for continuity of care, and improve outcomes.

VADM FAISON. A centralized, standardized appointment system for the entire Military Health System (MHS) will not improve access to care (ATC) because, except for multi-service markets (discussed next), MTFs are, in general, not proximal to each other's as one would find in civilian systems using centralized appointments where patients can easily drive between facilities to get the soonest appointment. In high military concentration areas where there is multi-service representation of Military Treatment Facilities (MTFs), this Multi Service Market standardization often makes sense and is in use today. In these areas, we share resources and capacity. Outside of these markets, we empower the MTFs to establish relationships, partnerships and systems that support local coordination for access to care that is patient-centered.

All Navy Medicine MTFs have some type of centralized appointment center. Our large Naval Medical Centers use a central appointment line for primary care and specific specialty clinic appointments. Smaller MTFs have a more decentralized arrangement that is both practical and economically feasible. Also, all Navy MTFs use nearly identical appointing processes and the same record system called the Composite Health Care System (CHCS). This allows for oversight and surveillance reporting for Health System performance in analytical tools.

Navy Medicine is very proud of our recent efforts that have improved access and developed two additional centralized appointing resources in use across our network of MTFs. We have also expanded appointment availability via the TRICARE Online website. Access to this website is available for all Navy MTF enrollees. For acute care needs, patients have the option of calling the Nurse Advice Line (1-800-TRICARE), which connects them to a registered nurse who is authorized to book care into our MTFs.

OPERATIONAL MEDICAL FORCE READINESS

5. Senator GRAHAM. LTG West, what is the actual total operational medical force readiness requirement for the Army?

LTG WEST. The total operational medical force readiness requirement for the Army is determined annually through the Total Army Analysis (TAA) process and is informed by current operational needs as validated by the Joint Staff. The current operational medical force requirements were last revalidated in TAA 18-22 in April 2015, totaling 20,478 requirements for Army Medicine soldiers.

This includes 5,262 requirements for Army Medicine soldiers assigned to medical units that perform missions above the Brigade Combat Team level such as our Combat Support Hospitals and Forward Surgical Teams.

Additionally, 12,051 Army Medicine soldiers are required to be assigned organically to other Army units such as Brigade Combat Teams, the US Army Special Operations Command, and key staff positions such as Command Surgeon offices in Army mission command headquarters.

Finally, the Medical Command (MEDCOM) contributes to medical force readiness by providing trained providers to operational force units through the Professional Filler System (PROFIS). Approximately 3,165 MEDCOM positions are categorized as PROFIS. This number reflects valid Operating Force requirements as well as other needs for PROFIS such as backfill of critical specialties in Reserve Component medical units where shortfalls exist.

6. Senator GRAHAM. Lt. Gen. Ediger, what is the actual total operational medical force readiness requirement for the Air Force?

Lt. Gen. EDIGER. 27,999.

7. Senator GRAHAM. VADM Faison, what is the actual total operational medical force readiness requirement for the Navy?

VADM FAISON. The 2016 program of record for Navy Medicine to support the operational requirement is 38,802 (Total Force Manpower Management System data as of 23 December 2015). This requirement represents funded billets, not assigned personnel. Navy Medicine exists to provide a rapidly deployable health care system across a wide variety of operational settings in support of the Warfighter.

Navy Medicine's Active Duty requirement is based on the operational mission in support of the Department of the Navy—the United States Navy (USN) and the United States Marine Corps (USMC). The modeling and analysis projections supporting our requirement for uniformed providers are derived directly from Combatant Commanders' Operational Plans coupled with the Medical Manpower All Corps Requirements Estimator (MedMACRE), a validated force planning tool. These plans

outline the capabilities required to prosecute various wartime scenarios based on the Secretary of Defense's Defense Planning Guidance. Navy Medicine's support to the operational requirement includes the following three major categories:

- Day to day organically assigned personnel to support operational Navy and USMC units (Ships, subs, squadrons, overseas hospitals).
- Capabilities needed to augment the day to day operational forces, other theater medical assets to support operational forces, and contingency operations across the globe (Hospital Ships, Casualty Receiving Treatment Ships, and Marine Corps units).
- Development, honing & sustainment consisting of personnel assigned to training pipelines, provision of mission-specific support (Students, Faculty, Logistics, Public Health, R&D).

8. Senator GRAHAM. Lt. Gen. Ediger, LTG West and VADM Faison, how long has it been since the Department evaluated and updated the Combatant Commands' (COCOM's) operational medical force readiness requirements?

Lt. Gen. EDIGER. The AFMS Critical Operational Readiness Requirements determination was last updated in 2013. The readiness demand signal has remained the same since that time. We update the requirements when there is a major change in our force structure or demand signal.

LTG WEST. The total operational medical force readiness requirement for the Army is determined annually through the Total Army Analysis (TAA) process and is informed by current operational needs as validated by the Joint Staff. TAA considers all COCOM daily operational requirements, defense strategic guidance, and other mission directives. These are modeled by the Center for Army Analysis to generate the total requirements and determine the resourcing within the programmed force constraints. TAA 18-22 was completed in April 2015. TAA 19-23 is ongoing.

VADM FAISON. Navy Medicine coordinates with OPNAV, Headquarters Marine Corps, and Naval Component Command Fleet staffs to update its requirements routinely throughout the Program Objective Memorandum (POM) process using the OSD directed Future Force Structure Planning Process, and revalidates that analysis each POM cycle.

The last major change in the OSD directed Future Force Structure Planning Process was in 2013 when OSD directed the use of the Integrated Security Construct Bravo (ISC-B) set of planning scenarios for use in POM-15 analysis. This analysis was also reflected in the Military Health System Modernization Study Report.

9. Senator GRAHAM. Lt. Gen. Ediger, LTG West and VADM Faison, what is the full cost to the taxpayers to sustain your Service's operational medical force readiness requirement?

Lt. Gen. EDIGER. The Fiscal Year 2017 Air Force associated full costs to taxpayers is \$6,269,204,000, which includes healthcare operations, research and procurement, as well as military personnel salaries for Air Force medical personnel, projected Medicare Eligible Retiree Healthcare Fund receipts, and Military Construction. Not included in this total are the Defense Health Agency costs for Private Sector Care attributed to Active Duty Air Force and their dependents, as well as the Defense Health Agency cost of shared services provided to the AFMS.

LTG WEST. The cost to taxpayers to sustain the operational medical force for the Army is between \$9.18 billion and \$9.38 billion annually. These readiness costs are split between the Army funded medical field units (20 percent) and the Defense Health Program (DHP) (80 percent). The medical costs within the Army are funded with Army Operations & Maintenance; Army Procurement; Army Research, Development, Test, and Evaluation (RDTE), Military Personnel appropriations pay for a force that is manned, equipped, and trained. Costs to support the Army National Guard and Reserve medical units are not included in these calculations.

VADM FAISON. On December 14, 2015, Deputy Secretary of Defense Work signed out a memorandum requiring the Services and the Defense Health Agency to define military medical force readiness and develop a model to determine and project the Department's cost for medical force readiness. Navy Medicine is actively participating in this effort.

10. Senator GRAHAM. Lt. Gen. Ediger, LTG West and VADM Faison, what percentage of the total Active medical force (officer and enlisted personnel) in your Service deployed to a combat theater each year over the last 15 years?

Lt. Gen. EDIGER. The following data is for Air Force deployments for combatant command requirements from 2001-2015 that were filled by Active Duty Air Force Medical Service members. This data does not account for the 873 Air Force servicemembers who are on Prepare to Deploy Orders in support of the SECDEF's

Global Response Force or United States Northern Command's Defense CBRNE (Chemical, Biological, Radiological, Nuclear, and Explosive) Response Force. This also does not include airmen supporting operations from AF installations, such as nuclear deterrence, cyberdefense, remotely piloted aircraft operations, intelligence operations centers, global mobility, long range strike and Homeland defense.

Year	Number of Deployments	AFMS AD End Strength	Percent of AFMS
2015	1,634	28,574	5.7%
2014	1,719	29,190	5.9%
2013	2,516	30,123	8.4%
2012	2,975	29,986	9.9%
2011	3,426	30,164	11.4%
2010	3,703	30,610	12.1%
2009	3,735	30,176	12.4%
2008	4,200	29,792	14.1%
2007	4,199	30,551	13.7%
2006	3,097	30,750	10.1%
2005	2,935	31,173	9.4%
2004	2,730	32,519	8.4%
2003	3,357	31,203	10.8%
2002	2,487	31,068	8.0%
2001	987	30,402	3.2%

LTG WEST. The percentage of total Active medical force (officer and enlisted personnel) that deployed to a combat theater over the last 15 years is as follows:

2001: 0.54% deployed
 2002: 1.70%
 2003: 6.56%*
 2004: 4.83%
 2005: 5.46%
 2006: 5.05%
 2007: 5.73%**
 2008: 5.05%
 2009: 6.96%***
 2010: 6.87%
 2011: 6.47%
 2012: 5.97%
 2013: 5.71%
 2014: 3.79%
 2015: 1.51%

Notes: *Initiation of OIF 1 in 2003 / **OIF Surge 2007–2008 / ***OEF Surge 2009–2011

VADM FAISON. We define a combat theater as an Active area of responsibility with ongoing combat operations (i.e. OIF, OEF). This does not include personnel deployed on exercises or in support of humanitarian assistance/disaster relief (HA/DR) operations like Haiti, Katrina, Ebola and similar Navy Medicine HA/DR support operations. In addition, a significant portion of Navy and Marine Corps forces are forward deployed and on station 24/7, 365 days a year. These forces routinely rotate in and out of combat theaters throughout their operational tours. Navy Medicine personnel are directly assigned to these operating forces as organic assets.

The table below represents the number of personnel deployed from shore-based Navy Medicine Medical Treatment Facilities (MTFs) compared to all Navy Medicine personnel assigned to these MTFs. Of note, the current Navy Medicine data application for tracking deployments was implemented in 2005. Data prior to 2005 is not available.

PRI—CAT	Fiscal Year										
	FY05	FY06	FY07	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15
Personnel	30,104	29,881	29,059	27,576	26,332	27,010	27,379	27,833	28,367	28,365	28,039
# Deployments	4,472	4,071	3,443	2,929	2,418	2,986	2,058	1,423	857	811	1,499
Percentage of Personnel Deployed	14.86%	13.62%	11.85%	10.62%	9.18%	11.06%	7.52%	5.11%	3.02%	2.86%	5.35%

Not included in the table above are the organically assigned Navy Medicine personnel within Navy and Marine Corps units. For fiscal year 2015 these are approximately 5,726 billets of the Active medical force assigned to the Marine Corps (Budget Submitting Office (BSO)-27), and 3,124 billets assigned to the Fleet (BSO-60, BSO-70). Historically, these organic assignments have remained stable over the last 10 years.

MILITARY PROVIDER PRODUCTIVITY

11. Senator GRAHAM. Lt. Gen. Ediger, LTG West and VADM Faison, does lower military provider productivity contribute to problems with access to care for beneficiaries?

Lt. Gen. EDIGER. When considering productivity of Air Force (AF) providers, it is important to consider that 87 of AF medical personnel are uniformed servicemembers. Also, 96 percent of AF medical personnel are assigned to AF hospitals and clinics with only 4 percent assigned to operational units. This means AF providers in hospitals and clinics are not only providing health care, but also constitute the deployable medical force and support day-to-day military operations at the installation. We believe AF providers are fully productive across a broad spectrum of responsibilities, which include readiness training and engagement with the missions they support to address operational health concerns. We adjust enrollment ratios to a level that is estimated to match the clinical availability of military providers, but sometimes mission priorities decrease availability and thus diminish access. We are developing a new enrollment tool to adapt enrollment ratios to particular missions and more precisely match capacity to demand.

It is also true that the AF has a significant number of relatively new providers due to turnover in the medical force. New providers are generally less productive clinically until they attain a certain level of experience. This is currently a factor in access to care due to the increase in new provider accessions over the past year subsequent to increased requirements for physician assistants and family nurse practitioners.

LTG WEST. The Medical Command continues efforts to better predict and mitigate operational readiness requirements in order to improve access to care for all beneficiaries. Nonetheless, essential operational medical readiness requirements, including military training requirements, may impact military provider availability; however, our staffing levels and mix of military and civilian or contract providers take these requirements into account.

VADM FAISON. Low provider productivity does not impact access to care for Navy Medicine. With regard to access performance, the Navy has the best performance in the Direct Care system. Further, our wait times for appointments outperform civilian benchmarks used by most health systems. Per MHS policy, MTFs are required to provide a primary care appointment within 24 hours to meet a patient's acute care needs. Navy Medicine routinely meets or outperforms this standard. By comparison, available civilian performance standards for acute appointments is typically 48 hours. Likewise, a routine primary care visit is required by our system within 7 days. By comparison, the civilian performance for a routine primary care visit is typically 10 business days or more. Lastly, Initial Specialty Care visits are required to be seen within 28 days for Navy MTFs. Navy Medicine meets or outperforms this standard in most cases when staff are available. Civilian specialty access varies widely by geographic region.

Navy Medicine performs much better than the policy requires. The MHS measures access to available appointments with an industry tool called the "3rd Next available" measure. By definition, this measure counts the first 3 open appointments available for every clinic in the system. This measurement is performed daily across all MTFs. For calendar year 2015, Navy Medicine recorded 1.0 days as the "3rd next measure" for acute primary care appointments; the MHS average for the period was 1.6 days. That means for an average day in Navy medicine, patients needing an acute appointment had three potential appointments to choose from in the next 1.0 days (24 hours). "3rd Next available" performance for routine appointments in primary care was 6.3 days and for initial specialty care appointments the value was 13.3 days: both leading values are well within the more stringent MHS standards.

To ensure quality access is maintained for our patients, our leadership at the MTF, Regional, and headquarters regularly track availability of appointments for patients using the "3rd Next available" measure.

The factors which contribute to high productivity and quality access performance are generally independent of available patient appointments. We manage our appointments to meet the needs of our patients.

12. Senator GRAHAM. Lt. Gen. Ediger, LTG West and VADM Faison, what are you doing now to increase provider productivity, which will lead to enhanced access to care?

Lt. Gen. EDIGER. Primary actions to increase clinical throughput pertain to team processes to serve the patient fully while focusing provider activities on assessment and provision of care. This involves more effective use of support staff protocols which leverage the skill sets of various team members to deliver care for minor medical issues that do not require direct intervention by the provider. A number of processes have been developed and implemented across the Military Health System and Air Force Medical Service to enhance access and create more avenues for getting patients to the right level of care at the earliest possible opportunity. Some of these programs include: secure messaging email between patients and their primary care team; opportunities for patients to be booked directly into certain specialty care providers without first seeing their provider; and the TRICARE Nurse Advice line which connects patients directly to a registered nurse for advice.

LTG WEST. Army Medicine methodically reviews primary care manager (PCM) clinical availability and productivity on a monthly basis. There is an established process that requires hospital, region, and headquarters approval for any non-standard activities that may take the provider out of the clinic. Additionally, PCM availability is summarized and briefed to the Deputy Commanding General for Operations. This process occurs monthly in order to focus on PCM availability and productivity which in turn improves access to primary care. Other initiatives to improve access to care include simplified appointing to reduce the number of appointment types, predictive tools to assess patient demand, and standardized time keeping/coding practices to ensure our providers are getting credit for the care they provide.

VADM FAISON. Navy Medicine leads the MHS in access to care performance, and our standards for performance exceed those for appointment availability in the private sector. Provider productivity does not impact access to care for Navy Medicine. In fact, provider clinical experience is important to us as part of skills preservation and sustainment for operational requirements.

Navy Medicine also leverages technology to increase patient opportunities for care outside of the traditional patient visit (virtual care). Navy currently leads the services with 51 percent of patients enrolled to use our secure messaging platform, Relay Health. In 2015, Navy patients sent 2.4 million secure messages to their health care teams. This tool allows clinic teams to answer medical issues via secure message that might otherwise have resulted in a clinic visit. Navy also utilizes the Nurse Advice line as an enhanced access tool available for our patients. In 2015, this tool allowed our patients to make 132,870 calls to a registered nurse, 36.9 percent of those calls resulted in a resolution to the patient's issue without an in-person medical facility visit needed. These systems have a 97 percent patient satisfaction: our patients like what we have done.

To ensure our providers have enough patients to both stay productive and sustain clinical skills, Navy Medicine recently enacted several recapture efforts based on the Patient Centered Medical Home strategy and model of primary care. By increasing enrollment of patients in our primary care clinics, we improve control of specialty care referrals because we can direct these patients to stay within our Military Treatment Facility (MTF). We also enjoy a contractual relationship with the Managed Care Support Contractor network that enables us to recapture network care that fits within the MTF capabilities using a "First Care Opportunity" or "Right of First Refusal" clause to redirect specialty care to a MTF, instead of incurring purchased care expenses for a resource available in our facility.

GRADUATE MEDICAL EDUCATION

13. Senator GRAHAM. Lt. Gen. Ediger, LTG West and VADM Faison, which of your Graduate Medical Education (GME) programs directly support COCOM operational medical force requirements? In other words, which GME programs, to include internships, residency programs and fellowship programs provide direct support to COCOM operational medical force requirements?

Lt. Gen. EDIGER. All of the Air Force GME programs either directly or indirectly support COCOM medical operational force requirements. The spreadsheet below provides a list of Tier 1 GME programs whose graduates fill Unit Type Code (UTCs) that directly support COCOM requirements. The remaining Tier 2 GME programs are required to maintain accreditation of Tier 1 GME programs, fill required OCONUS billets and deliver necessary health care to Department of Defense (DOD) personnel who will support COCOM requirements.

USAF ACTIVE DUTY TRAINING PROGRAM		Scenario 1			Scenario 2			Definitions:
	TIER	1	2	3	1	2	3	
AEROSPACE MEDICINE								Scenario 1: Operational billets as defined by training requirement necessary for placement on deployment UTC
ALLERGY & IMMUNOLOGY								
ANESTHESIOLOGY								
DERMATOLOGY								
EMERGENCY MEDICINE								
EMERGENCY MEDICINE EMS FELLOWSHIP								
EMERGENCY MEDICINE ULTRASOUND FELLOWSHIP								
FAMILY MEDICINE								
FAMILY MEDICINE - SPORTS MEDICINE FELLOWSHIP								
INTERNAL MEDICINE								Scenario 2: This includes all operational billets as defined above as well as overseas billets as these provide medical readiness support for forward-deployed personnel and care for their families
INTERNAL MEDICINE CARDIOLOGY FELLOWSHIP								
INTERNAL MEDICINE ENDOCRINOLOGY FELLOWSHIP								
INTERNAL MEDICINE GASTROENTEROLOGY FELLOWSHIP								
INTERNAL MEDICINE HEMATOLOGY/ONCOLOGY								
INTERNAL MEDICINE INFECTIOUS DISEASE FELLOWSHIP								
INTERNAL MEDICINE NEPHROLOGY FELLOWSHIP								
INTERNAL MEDICINE PULMONARY/CC FELLOWSHIP								Tier 1: essential capability required in uniform at all times for wartime, crisis situations
INTERNAL MEDICINE RHEUMATOLOGY FELLOWSHIP								
NEUROLOGY								
OB/GYN								
OPHTHALMOLOGY								
ORTHOPEDIC SURGERY								
OTOLARYNGOLOGY								
PATHOLOGY								
PATHOLOGY CYTOPATHOLOGY FELLOWSHIP								
PEDIATRICS								Tier 2: MTF capability required to maintain accreditation of Tier 1 programs; fills OCONUS billets; complementary GME essential to Tier 1 GME
PEDIATRICS ADOLESCENT MEDICINE								
PEDIATRICS DEVELOPMENTAL FELLOWSHIP								
PEDIATRICS INFECTIOUS DISEASE								
PEDIATRICS NEONATOLOGY								
PREVENTIVE MEDICINE								
PSYCHIATRY								
RADIOLOGY - DIAGNOSTIC RADIOLOGY								
RADIOLOGY - MUSCULOSKELETAL								
SURGERY - CRITICAL CARE / TRAUMA FELLOWSHIP								Tier 3: Non-OCONUS only billets
SURGERY - GENERAL SURGERY								
SURGERY - VASCULAR SURGERY								
TRANSITIONAL PROGRAM								
UNDERSEA AND HYPERBARIC MEDICINE								
UROLOGY								

Note a RED X in tier 2 denotes members with this skill set ready to deploy in a Tier 1 position at all times.

LTG WEST. Current Army Graduate Medical Education (GME) physician training programs constitute the near exclusive pipeline for physicians providing direct COCOM support. The programs train physicians that provide health care directly contributing to COCOM medical force readiness by ensuring the readiness of the force and by developing the clinical skills necessary for the provision of direct care to the ill and injured for combat casualty care and humanitarian contingency operations. These programs develop critical clinical competencies that are fully aligned with the 31 August 2015 Joint Concept for Health Services Joint Medical Capabilities. Training program throughput is fully aligned with the Total Army Analysis sizing model operational wartime requirements.

Most of these programs are conducted at Army military treatment facilities that also provide direct health care to combat casualties. These programs enhance hospital clinical capability and patient access to emerging state of the art diagnostics and therapeutics. These programs are also strategically placed to maximize opportunities for full health care team training and permit leveraging of assets to support co-located non-physician training programs (e.g., nursing, dental, allied health, etc.).

Army Medicine hosted or sponsored residency programs that provide direct support to COCOM operational force medical requirements include: Aerospace Medicine; Anesthesiology; Dermatology; Emergency Medicine; Family Medicine; General Surgery; Internal Medicine; Neurology; Neurosurgery; Obstetrics-Gynecology; Occupational Medicine; Ophthalmology; Orthopaedics; Otolaryngology; Pathology; Pediat-

rics; Physical Medicine; Plastic Surgery; Preventive Medicine; Psychiatry; Psychiatry/Internal Medicine; Diagnostic Radiology; and Urology.

Army Medicine hosted internship programs that provide direct support to COCOM operational force medical requirements include: general Transitional Year and designated Preliminary Transitional Year training programs preceding full residency training in Dermatology, Ophthalmology, Physical Medicine, Preventive Medicine, and Diagnostic Radiology.

Army Medicine hosted or sponsored fellowship programs that provide direct support to COCOM operational force medical requirements include: Adolescent Medicine; Critical Care; Blood Banking/Transfusion Medicine; Critical Care Ultrasound; Emergency Medicine Subspecialties (Austere & Wilderness Medicine, Cardiology, Emergency Medicine Services & Disaster Medicine, Emergency Toxicology, Pediatrics, Sports Medicine, Ultrasound); Family Medicine Subspecialties (Obstetrics, Psychiatry, Gastroenterology/Colonoscopy, Hospitalist, Sports Medicine); General Surgery Subspecialties (Colon/Rectal, Craniofacial, Pediatric, Thoracic, Trauma/Critical Care, Vascular); Internal Medicine Subspecialties (Cardiology, Gastroenterology, Hospitalist, Infectious Disease, Nephrology, Pulmonary/Critical Care Medicine); Neurology Subspecialties (Critical Care, Neuro-Ophthalmology); Neurosurgery Subspecialties (Trauma/Critical Care, Pain & Functional, Pediatric, Peripheral Nerve, Skull Base, Spine, Vascular); Obstetrics-Gynecology Subspecialties (Female Pelvic Medicine & Reconstructive Surgery, Maternal & Fetal Medicine); Occupational Medicine-Preventive Medicine; Ophthalmology Subspecialties (Corneal/External Disease, Neuro-Ophthalmology, Oculoplastic/Orbital, Pediatric, Retinal); Orthopaedic Subspecialties (Adult Reconstructive/Total Joint, Sports Medicine, Foot and Ankle, Hand, Musculoskeletal Oncology, Trauma, Pediatric, Shoulder & Elbow, Spine); Otolaryngology Subspecialties (Facial Plastic/Reconstructive, Head & Neck); Pain Management; Pediatric Anesthesia; Pediatric Subspecialties (Cardiology, Critical Care, Infectious Diseases, Neonatology, Pulmonary/Critical Care Medicine); Physical Medicine Subspecialties (Sports Medicine, Traumatic Brain Injury); Preventive Medicine-Occupational Medicine; Psychiatry Subspecialties (Addiction, Child/Adolescent, Preventive Psychiatry); Radiology Subspecialties (Musculoskeletal Imaging, Neuroradiology, Pediatric, Vascular/Intervention); Sleep Medicine; Urology Subspecialties (Female, General, Stone/Laparoscopy, Trauma Reconstructive).

VADM FAISON. All Navy, joint and civilian clinical GME programs attended by Navy Medical Corps personnel directly relate to the provision of medical operational requirements. The importance of maintaining quality control over physician training through our GME programs is grounded in the diversity of the remote, austere, and challenging environments in which our providers routinely operate in contrast to locations where most graduates of civilian residency programs will practice. The programs in support of operational requirements fall under two categories – primary or secondary.

Primary programs refer to those for which Medical Manpower All Corps Requirements Estimator (MedMACRE) classifies the billets as operational. These include sea duty billets such as aboard an air craft carrier, and remote land based billets such as Administrative Support Unit Bahrain. In addition, it includes overseas billets as these provide medical readiness support to forward-deployed military personnel.

Secondary programs are those not in immediate support of the readiness mission, but are in direct support of GME programs (required for accreditation).

Examples of primary and secondary programs are as follows:

Primary:	Internal Medicine Residency
Secondary:	Internal Medicine Cardiology Interventional Fellowship
Primary:	Family Medicine Residency
Secondary:	Family Medicine Faculty Development Fellowship
Primary:	Obstetrics/Gynecology
Secondary:	Family Planning Fellowship Obstetrics/Gynecology Urology Fellowship
Primary:	Pediatrics Residency
Secondary:	Pediatric Endocrinology Fellowship Pediatric Gastroenterology Fellowship

All Navy GME programs are fully accredited by the American college of Graduate Medical Education (ACGME), and 95 percent of our graduates pass their board certification at the first sitting. This strong approach to military physician training and GME allows us to assure American families that the providers caring for their sons

and daughters, regardless of location, are among the best in the nation. These future leaders of the operational medical force are well prepared to save lives and protect health, which is a core responsibility of the operational combatant commander.

14. Senator GRAHAM. Lt. Gen. Ediger, LTG West and VADM Faison, how many personnel in each Service are currently training in those direct support programs?

Lt. Gen. EDIGER. There are 859 Air Force trainees in Department of Defense Graduate Medical Education (GME) programs.

LTG WEST. Approximately 75 Army medical officers are currently training in a one year medical internship program. Army Medicine hosted internship programs that provide direct support to COCOM operational force medical requirements include the following programs and number of Army officers currently in training: General Transitional Year (47), and designated preliminary Transitional Year training programs that precede full residency training in Dermatology (7), Ophthalmology (5), Physical Medicine (3), Preventive Medicine (1), and Diagnostic Radiology (12).

Approximately 1141 Army medical officers are currently training in a medical residency program. Army Medicine hosted programs or sponsored civilian residency training that provide direct support to COCOM operational force medical requirements include the following programs and number of Army officers currently in training: Aerospace Medicine (19); Anesthesiology (14); Dermatology (27); Emergency Medicine (105); Family Medicine (140); General Surgery (113); Internal Medicine (167); Neurology (13); Neurosurgery (17); Obstetrics-Gynecology (75); Occupational Medicine (5); Ophthalmology (22); Orthopaedics (97); Otolaryngology (34); Pathology (29); Pediatrics (82); Physical Medicine (15); Plastic Surgery (6); Preventive Medicine (8); Psychiatry (57); Psychiatry/Internal Medicine (2); Diagnostic Radiology (63); and Urology (30).

Approximately 160 Army medical officers are currently training in a medical fellowship subspecialty training program. Fellowship training is based on current mission critical needs of Army Medicine that in part is driven by separations and retirements of previously trained experts. Thus training is not conducted in every subspecialty every year. Army Medicine hosted programs or sponsored civilian fellowship training that provide direct support to COCOM operational force medical requirements include the following programs and number of Army officers currently in training: Adolescent Medicine (4); Critical Care (2); Blood Banking/Transfusion Medicine (0); Critical Care Ultrasound (0); Emergency Medicine Subspecialties (Austere & Wilderness Medicine (2), Cardiology (0), Emergency Medicine Services & Disaster Medicine (3), Emergency Toxicology (1), Pediatrics (2), Sports Medicine (1), Ultrasound (3)); Family Medicine Subspecialties (Obstetrics (1), Psychiatry (0), Gastroenterology/Colonoscopy (1), Hospitalist (1), Sports Medicine (2)); General Surgery Subspecialties (Colon/Rectal (2), Craniofacial (1), Pediatric (2), Thoracic (1), Trauma/Critical Care (4), Vascular (6)); Internal Medicine Subspecialties (Cardiology (14), Gastroenterology (19), Hospitalist (0), Infectious Disease (9), Nephrology (2), Pulmonary/Critical Care Medicine (14)); Neurology Subspecialties (Critical Care (1), Neuro-Ophthalmology (0)); Neurosurgery Subspecialties (Trauma/Critical Care (0), Pain & Functional (0), Pediatric (0), Peripheral Nerve (0), Skull Base (0), Spine (2), Vascular (0)); Obstetrics-Gynecology Subspecialties (Female Pelvic Medicine & Reconstructive Surgery (4), Maternal & Fetal Medicine (7)); Occupational Medicine-Preventive Medicine (0); Ophthalmology Subspecialties (Corneal/External Disease (1), Neuro-Ophthalmology (0), Oculoplastic/Orbital (0), Pediatric (1), Retinal (0)); Orthopaedic Subspecialties (Adult Reconstructive/Total Joint (2), Sports Medicine (2), Foot and Ankle (0), Hand (4), Musculoskeletal Oncology (0), Trauma (0), Pediatric, Shoulder & Elbow (0), Spine (2)); Otolaryngology Subspecialties (Facial Plastic/Reconstructive (1), Head & Neck (0), Pediatric (1)); Pain Management (5); Pediatric Anesthesia (0); Pediatric Subspecialties (Cardiology (0), Critical Care (2), Infectious Diseases (1), Neonatology (5), Pulmonary/Critical Care Medicine (2)); Physical Medicine Subspecialties (Sports Medicine (0), Traumatic Brain Injury (0)); Preventive Medicine-Occupational Medicine (2); Psychiatry Subspecialties (Addiction, Child/Adolescent (7), Preventive Psychiatry (0)); Radiology Subspecialties (Musculoskeletal Imaging (2), Neuroradiology (4), Pediatric (0), Vascular/Intervention (2)); Sleep Medicine (3); Urology Subspecialties (Female (0), General (0), Stone/Laparoscopy (0), Trauma Reconstructive (0)).

VADM FAISON. In fiscal year 2015, there were 991 Navy Medical Corps personnel attending Navy, joint or civilian clinical GME direct support programs.

15. Senator GRAHAM. Lt. Gen. Ediger, LTG West and VADM Faison, are there any direct support programs that could be eliminated from each Service while main-

taining the essential medical capabilities of the Services to perform combat casualty care, higher echelon casualty care, and humanitarian assistance?

Lt. Gen. EDIGER. No.

LTG WEST. All current graduate medical education training programs identified as providing direct COCOM support are fully aligned with joint medical capability requirements outlined in the 31 August 2015 Joint Concept for Health Services. The Army Medical Department reviews graduate medical education programs on an annual basis to assure training meets clinical capability mission requirements. In addition, a comprehensive Army Graduate Medical Education program review has been initiated to further optimize graduate medical education alignment with readiness, critical skills, and system for health priorities.

VADM FAISON. No, all Navy, joint and civilian clinical GME programs attended by Navy Medical Corps personnel relate to the provision of medical operational requirements.

MISSED APPOINTMENTS

16. Senator GRAHAM. Lt. Gen. Ediger, LTG West and VADM Faison, from October 2014 through September 2015, there were over 1.6 million scheduled appointments missed by all categories of beneficiaries. Active Duty servicemembers missed over 700,000 of those scheduled appointments. How much money did missed appointments cost your Service, and ultimately the taxpayers, during this time period?

Lt. Gen. EDIGER. Note that the number of patients seen as “walk-ins” in Air Force primary care clinics exceeds the number of no-shows. While the following calculation presents the value of appointments equivalent to the number of no-shows, most of this capacity is utilized to provide care for walk-in patients.

From October 2014 through September 2015, the potential cost of beneficiaries missing their medical appointments is approximately \$28M. The data used to generate this estimate reflects fiscal year 2015 encounters for privileged providers only and excludes any dental appointments. Methodology used to calculate potential cost of missed medical appointments/no-shows:

Average Provider Aggregate Relative Value Unit (paRVU) per encounter (x) Total number NoShows=Total Provider Aggregate Relative Value Units (paRVU) NoShows

Provider Aggregate Relative Value Units (paRVU) NoShows (x) fiscal year 2015 Prospective Payment System (PPS) cost=Value

This methodology uses a Prospective Payment System (PPS) value to determine the “value” of the no show encounter. The PPS value is not adjusted for geographic location. Additionally, this method does not consider the impact of over-booking or filling vacated patient appointments with walk-ins. The system does not permit tracking the number of missed appointment slots which are booked by last minute appointments or walk-ins. This method also does not take into account opportunity costs, the true cost of delivering the care (vs. MEPRS allocated cost) or the cost associated with delivering direct/indirect care to support Active Duty (PHAs, MEBs, security clearance record reviews) or the time providers and staff are required to spend outside the healthcare delivery system (readiness training, leadership activities, etc.).

LTG WEST. During the timeframe of October 2014 through September 2015 Army Medicine scheduled 9.6M appointments for all beneficiary categories. Of those scheduled appointments, 591,500 or 6.2 percent were recorded as a missed appointment. The estimated cost of a missed appointment is approximately \$204. Therefore we estimate the total cost of missed appointments during fiscal year 2015 is \$120.6M for all beneficiaries. Army Medicine has made a concerted effort to decrease no show rates. Our latest data shows improvement in this area. For the twelve months ending in February 2016, our no-show rate decreased to 4.8 percent.

VADM FAISON. No show rates for Navy Medicine are well below civilian averages. In fiscal year 2015, Navy MTFs saw a total of 42.5 million patient encounters. During this period, the total percentage of missed appointments when compared to the overall number of clinical encounters was 3.77 percent. Civilian rates of patients failing to keep appointments typically range from 6 percent to 30 percent, depending on the type of patient population.

Our methods for attaining low no-show rates are a mixture of patient reminders, phone call patient confirmations, patient engagement by clinical staff, identifying high no-show patients, and use of a beneficiaries’ chain-of-command to reinforce the importance of appointment attendance.

We aggressively work to fill missed appointments with walk-in patients. These are patients who otherwise would have sought their care in either an Emergency

Room or in the network. This allows us to both fully utilize our available appointments while decreasing costs for Emergency Room and network care.

17. Senator GRAHAM. Lt. Gen. Ediger, LTG West and VADM Faison, how significantly do these missed appointments affect your ability to provide timely care to other beneficiaries?

Lt. Gen. EDIGER. The Air Force experiences a no-show rate of approximately 5–7 percent, which is consistent with civilian industry. Although this is not a significant percent of the care we schedule, it does impact our patient's ability to schedule appointments. To mitigate the impact of missed appointments and provide additional access, clinics walk-in patients to take care of the most urgent needs as quickly as possible. Note that the number of walk-in patients seen in AF primary care clinics exceeds the number of no-shows.

LTG WEST. Each patient no-show impacts both the patient and the system. Missed appointments can contribute to increased patient dissatisfaction with the timeliness of care. Missed appointments impact our ability to ensure readiness and positive outcomes for soldiers and beneficiaries. No-show appointments also represent a lost opportunity to provide healthcare services to beneficiaries and because they often result in rescheduled appointments, they reduce overall appointment availability and impact our ability to meet Access to Care standards. Over the past 3 years, Army Medicine's no-show rate has reduced from 6.6 percent to 4.8 percent. We remain committed to working with line leaders and educating patients on the negative impact that no-shows have on the direct care system.

VADM FAISON. Missed appointments/no-shows in Navy Medicine do not significantly impact beneficiary access to care. This is evidenced by the fact that no-show rates for Navy Medicine are well below the civilian averages (i.e., 3.77 percent in Navy Medicine vs. 6 percent–30 percent civilian averages) and Navy Medicine's access to care performance leads the Military Health System (e.g., Navy Medicine leads all Services in third-next available appointments and average days to be seen). We have no evidence that our low rate of missed appointments impedes, in any way, timely access to care by our other beneficiaries.

18. Senator GRAHAM. Lt. Gen. Ediger, LTG West and VADM Faison, what are you doing to fix this important problem—a problem that hinders access to care for all beneficiaries and wastes taxpayer dollars?

Lt. Gen. EDIGER. To minimize the volume of missed appointments, Air Force Military Treatment Facilities utilize an automated calling system to remind patients of scheduled appointments. The Air Force Medical Service also utilizes “no-show posters” as well as other education tools to inform patients of the impact of missing appointments. Some Military Treatment Facilities also send “no-show” letters to patients who miss their appointments to remind them of the importance of making their scheduled appointments. The Air Force Medical Service also educates patients on the benefits of the TRICARE Online notification system, which after sign-up provides the patient multiple notification options to include email and/or text.

LTG WEST. We are deeply involved in initiatives to reduce missed appointments such as simplifying appointment cancellation procedures and utilization of tools such as TRICARE Online which provides organic email and text messaging appointment reminders directly to the beneficiary. Our facilities also use telephonic appointment reminder services that provide recorded reminder messages to our beneficiaries. Finally, we actively partner with the leadership of our posts, camps, stations and bases through community outreach efforts to ensure that we educate the beneficiary population on the value of their care provided at their medical treatment facility. In so doing we provide a consistent message concerning the importance of keeping appointments or cancelling them in a timely manner.

VADM FAISON. No-show rates for Navy Medicine are well below civilian averages. In fiscal year 2015, Navy Military Treatment Facilities (MTFs) saw a total of 42.5 million patient encounters. During this period, the total percentage of missed appointments when compared to the overall number of clinical encounters was 3.77 percent. Civilian averages of patients failing to keep appointments typically range from 6 percent to 30 percent, depending on the type of patient population.

Navy Medicine has achieved this success via Active engagement at the local level and delegated to MTF leadership. Across our MTFs, staff utilize a mixture of patient reminders, phone call patient confirmations, patient engagement by clinical staff, identifying high no-show patients, and use of a beneficiaries' chain-of-command to reinforce the importance of appointment attendance. This strategy has proven successful in achieving and sustaining no-show rates much lower than those seen in the private sector.

MEDICAL HEADQUARTERS STAFFING

19. Senator GRAHAM. Dr. Woodson, we have data to show that total medical headquarters staffing—military, civilian and contractor personnel in the Defense Health Agency and the Services combined—is over 12,000 persons.

Do you think this is the right number of headquarters staff? If not, what is the right number of personnel required to manage the military health system?

Dr. WOODSON. Thanks for the opportunity to clarify this misconception that all 12,000 members of the DHA are categorized as “headquarters staff.” In the DHA, we have about 9000 personnel working in the military treatment facilities at Walter Reed and Ft Belvoir, providing healthcare directly to patients. We have about 2600 personnel working in consolidated shared services in ten functional areas, providing support directly to the Army, Navy, and AF military treatment facilities located around the world. In addition, the DHA has absorbed a number of organizations such as the Armed Forces Medical Examiner System (AFMES), DOD Medical Examination Review Board (DODMERB), Medical Education & Training Campus (METC), and Defense Center of Excellence (DCoE), which formerly were Executive Agencies and also provide enterprise support to the Services’ medical missions. We expect that additional organizations will be absorbed into DHA in fiscal year 2017 and fiscal year 2018. The DHA has dedicated resources to assessing its manpower requirements as a result of these consolidations. We will continue to identify manpower reductions, while maintaining the high quality expected of military healthcare.

20. Senator GRAHAM. Dr. Woodson, should DOD further shrink medical headquarters staffs through additional consolidation of the headquarters functions of the DHA and the Services? If not, why not?

Dr. WOODSON. Yes, we need to be constantly looking for ways to improve efficiency and eliminate unproductive duplication and variation. Realistically, there is a limit on how much change can be implemented quickly without risking breakdowns. There is clearly more to do.

TRICARE MEDICAL SUPPORT CONTRACTS

21. Senator GRAHAM. Dr. Woodson, why were the requirements for the next round of TRICARE medical support contracts based on a non-risk bearing contracting strategy that purchases medical services and procedures, instead of a risk-bearing contract strategy that purchases improved health outcomes and higher patient satisfaction?

Dr. WOODSON. TRICARE Medical Support Contracts are considered to be risk-bearing contracts. The T-2017 contract makes a number of important changes to how the Military Health System delivers care, including improvements to beneficiary experience and the measurement of quality, and holds the contractors responsible for these outcomes. In addition the National Trend Incentive provides a financial incentive for performance. We are also developing and implementing a number of value-based care demonstrations which place providers at risk for quality outcomes and efficiency, and anticipate these will continue to expand during the life of the T-2017 contract. Our goal is to have 80 percent of all MHS private sector healthcare expenditures be tied to quality and efficiency by 2020, and to integrate this effort with the direct care system. Thus by the end of the T-2017 contract, we anticipate that most of our expenditures will be based on outcomes, not volume. We believe this is the best approach to ensure our beneficiaries have great access to outstanding care, and that our scarce resources are used in the most efficient and effective way possible.

HEALTHCARE COSTS

22. Senator GRAHAM. Lt. Gen. Ediger, LTG West and VADM Faison, military hospitals and clinics produce inpatient/outpatient workload at costs about 50 percent higher than what it would cost if those services were purchased in the private sector.¹ Why does it cost more to provide health care services in military hospitals than it cost to purchase the same services in the private sector?

Lt. Gen. EDIGER. The Military Health System provides medical capabilities, not just a medical benefit associated with providing direct care. The AFMS provides the Nation with Medically Ready Airmen, medical support to the nuclear mission, Bio-environmental Engineering and Public Health, and a trained medical force ready to save lives in garrison as well as in expeditionary settings.

- 1) Maintaining Medically Ready Airmen and providing the care necessary to our Active Duty force consumes about 16 percent of our budget. This averages out

to about \$181 per Direct Care visit vs the \$131 to purchase their care (doesn't include the overhead costs paid to the Managed Care Support Contractors to administer the benefit). This is closer to a 28 percent difference, which we continually work to decrease by improving health through Medical Home initiatives, preventive medicine, and performance management in order to gain efficiencies where the mission allows.

- 2) Graduate medical and dental education, education and training, and Phase II Training programs account for 2 percent of the total costs.
- 3) Support for the AF's Mission includes provision of environmental, industrial, and occupational health via Bioenvironmental Engineering and Public Health programs, as well as direct support provided to AF Line units outside of providing the peacetime health benefit to include the Personnel Reliability Program and Dover Mortuary Support, which accounts for 9 percent of costs.
- 4) We maintain overseas military hospitals and Military Treatment Facilities (MTFs) to provide a US standard of care in countries where we maintain a military presence; this accounts for 12 percent of our budget.

Reimbursements from private insurance payers are not considered, which would decrease the cost of care provided within an MTF by approximately 11 percent if considered.

In summary, the total cost of these mission-essential capabilities account for about 39 percent of our total budget. Although there is some overlap in providing the care to ensure Medically Ready Airmen, the costs of ensuring a medically ready and trained force, direct support to the AF Mission and support to MTFs have not been effectively carved out of the cost allocation, because they are interrelated and dependent. A simple 50 percent cost comparison does not fully account for the fact that almost 40 percent of our total budget is allocated towards supporting the total readiness of the medic, warfighter readiness, and the health of our installations.

LTG WEST. Actually, the Army is able to provide inpatient hospital services at a lower cost than most private sector hospitals. Analysis of fiscal year (FY) 2015 Army inpatient care and its inpatient supporting services reflect the Army inpatient cost-per-stay (disposition) is \$11,528.10. Published research of hospital inpatient costs demonstrates a wide variation of civilian inpatient costs. The range of civilian inpatient cost-per-stay, inflation adjusted for 2015, is between \$11,557 and \$17,562 per stay nationally for civilian hospitals. The Army inpatient cost per stay compared to civilian inpatient cost per stay, therefore is less expensive by 0.3 percent to 52.3 percent.

Army outpatient services include emergency services, outpatient surgery, outpatient ancillary services, and professional primary care and specialty care encounters. Analysis of fiscal year 2015 Army outpatient care (excluding dental) and its supporting outpatient services reflect the Army outpatient services average cost per encounter is \$237.03 and the Purchased Care average cost of a paid claim is \$154.60. The Army average cost per encounter variance is \$82.43 or 53 percent higher. The Army cost is higher due to functions not performed by Purchased Care practices such as "readiness of the force" activities (e.g. soldier readiness processing activities, Integrated Disability Evaluation System processes, flight medicine, and other similar functions). Additionally, Army hospitals/clinics are required to provide programs and functions affecting the Active Duty family member that include Early Interventional Program and Exceptional Family Member Programs, and respond to infectious disease threats. These types of programs occurring in the civilian sector are normally managed by state organizations. The medical treatment facility responses in these situations contribute to the overall readiness of the force and a higher average cost per encounter ratio.

VADM FAISON. It is not possible to accurately compare the Direct Care system (i.e., care delivered in military treatment facilities) to care delivered in the private sector. Navy Medicine is a rapidly deployable, fully integrated medical system and this is what sets us apart from civilian medicine. Our direct care system serves as the readiness and surge platform for our providers and is critical to sustaining the vital skills and clinical competencies for our medical force.

Additionally, the range of costs for the same surgical procedure in the private sector can vary widely, making it difficult to equate to procedures performed in the direct care system. In the Federal Health Care Benefit, Blue Cross costs more than Kaiser Permanente—an HMO. Of course HMOs control costs with limited choice in doctors, specialists, high co-pays and limits on access to care. These same tools are not used in the military health care system in order to ensure choice, provide high quality care, and maximize access for our Active Duty servicemembers, retirees, and dependents as part of the TRICARE benefit.

Finally, Direct Care costs include the cost of readiness. We understand there is a desire to separate out these costs, and we are working towards a solution. Our

goal in Navy Medicine is to provide exceptional value to those we serve by ensuring superior health outcomes through the safest and highest quality care, convenient access, full and efficient utilization of our services, and lower care costs.

23. Senator GRAHAM. Lt. Gen. Ediger, LTG West and VADM Faison, what is the cost of readiness?

Lt. Gen. EDIGER. The cost of readiness in fiscal year 2017 is forecasted to be \$5,487,586,000, which includes healthcare operations as well as salaries for Air Force medical personnel. Not included in this total are funds associated with modernization of facilities and equipment, Medicare Eligible Retiree Health Care Fund receipts, and Private Sector Care costs attributable to Active Duty Air Force and their dependents.

LTG WEST. The cost of readiness within the Army's Defense Health Program (DHP) appropriation is approximately \$7.32 billion annually. This cost accounts for 61.7 percent of the total funding received by the Army within the DHP.

VADM FAISON. Navy Medicine is a rapidly deployable, fully integrated medical system and this is what sets us apart from civilian medicine. It exists to support readiness and the operational missions of both the Navy and Marine Corps. In the context of the cost of readiness, we must recognize that fundamentally readiness includes the costs of keeping sailors, marines and their families healthy and medically ready to deploy. Our direct care system serves as the readiness platform for our providers and is critical to sustaining the vital skills and clinical competencies for our medical force.

The cost of readiness encompasses multiple factors that fall outside of the scope of Navy Medicine. In considering the complex nature of how this estimate would be derived, a number for the cost of readiness cannot be determined at this time. In conjunction with DOD, DHA, and the other Services (as per the Deputy Secretary of Defense memorandum of 14 Dec 15), we are working towards a solution that begins to inform this effort. The development of the Essential Medical Capabilities across the services will provide a uniform standard that will help support the development of a model for the cost of one component, medical force readiness. This will also align Navy Medicine with how the Navy line estimates the cost of their readiness.

MEDICAL STAFF CONTRACTING

24. Senator GRAHAM. VADM Bono, what are your thoughts on a capability-based, outcomes-driven contracting model for contracted medical services rather than the present focus on "piece-meal" staffing augmentation? Has DHA considered implementing such a model? If so, what is the status? If not, why not?

VADM BONO. Contracted medical services purchased to augment military treatment facilities have not traditionally used an outcomes-driven contracting model for several reasons. First, this model requires that the contractors have control of the factors that enable them to meet or exceed the Government's outcome goals. Contracted staff members supplement military and civilian staffs in providing care and are integrated into provider and support teams. The contractor is not in control of the hospital's productivity schedule and associated support functions of laboratory, pharmacy, health information technology that would allow it to achieve an outcomes-driven model. Second, the augmentation model allows maximum flexibility for military treatment facilities to fill vacancies associated with deployments and other staffing gaps and to add staff in case of national emergencies without affecting or altering military or civilian positions. Patient care can continue in the facilities and, when military or civilian health care workers become available, contracts can be reduced at the Government's option. Finally, this model supports a robust small business health care staffing industry. According to the Federal Procurement Data System, the military spent over \$1.3B in fiscal year 2015 on direct health care services using small business providers that are capable of finding, hiring and staffing these positions.

DHA currently implements an outcomes-driven staffing model in two National Capital Region facilities—the Dumfries and Fairfax Health Centers. According to GAO, these two clinics represented 23 percent of contract health care professionals in the National Capital Region in fiscal year 2011. These clinics represent an effective use of an outcomes-driven contracting model where the contractor has full control of the staffing and provision of ancillary services.

To date, DHA has not considered segregating functions within its military treatment facilities for outcomes-driven contracting because doing so would involve changing hospital military and civilian staffing models, which could affect the readiness and training missions of the facilities. The inability to split ancillary support

services between contractor and Government-run operations could result in the contractor's inability to meet contractual metrics and result in requests for equitable adjustment. Finally, the augmentation model provides the required flexibility while supporting robust Small Business contracting opportunities for the Department of Defense.

QUESTIONS SUBMITTED BY SENATOR KIRSTEN E. GILLIBRAND

ABA THERAPY FOR AUTISM

25. Senator GILLIBRAND. Dr. Woodson, when I asked you about the proposed changes in reimbursement rates for Applied Behavior Analysis (ABA) therapy, you stated that DHA "commissioned two outside studies that confirmed we were overpaying." I have reviewed these studies, and I'm concerned that the studies found dramatically different reimbursement rates from each other. Yet, you selected one set of reimbursement rates, the Medicaid plus 20 percent rate, seemingly at random. How do you justify your selection of the Medicaid plus 20 percent rate?

Dr. WOODSON. By statute, all TRICARE reimbursement rates mirror Medicare rates to the extent practicable. Because Medicare has not set rates for ABA services, we had to use an alternative method of calculating rates. If and when Medicare rates are established, those rates will be immediately adopted, so it is crucial the calculation formula chosen to determine the rates be based on data that can be positively confirmed and approximates the likely future Medicare rates to the greatest extent possible. This approach is most fair to all providers. The adopted rate calculation process ensures establishment of ABA rates based on external studies, a consistent and fair calculation process for all localities, an annual review of the rates like all other TRICARE rates, an approach that approximates future Medicare rates, and rates adjusted for the 89 geographic areas that are recognized by Medicare.

Kennell provided us with four different possible approaches to setting rates, some of which did include commercial rates. The National Rate option chosen was determined to be the best predictor of where Medicare rates will eventually be set. This option was based on adjusting the average Medicaid rates to calculate a "predicted" Medicare rate. On average, the Medicare rates are about 22 percent higher than Medicaid rates for a sample of the three highest-volume individual mental health service codes. This selected methodology was not chosen at random, but chosen to provide a consistent calculation of rates for all localities based on rates that can be positively confirmed by each State versus trying to use commercial rates, which are proprietary and vary greatly due to different billing codes, types of Plans (HMO, PPO, indemnity, etc.) and types of providers.

The intent of the 2016 reimbursement rates is to align the ABA reimbursement rate methodology with that used annually for all other TRICARE rates generally, to include locality adjustments, while ensuring excellent access for our beneficiaries and a very competitive rate for TRICARE providers. This action results in the rates being reviewed and appropriately adjusted each year, like all other TRICARE rates, and not frozen for another 7-year period.

The current rates we are replacing have been used for over 7 years, with no change, and with the same rate paid in all locations, unlike all other TRICARE, Medicare, and commercial rates which are adjusted for each geographic locality. The current rates were arbitrarily set in 2008 under the Extended Care Health Option Enhanced Access to Autism Services Demonstration Program, which was designed as educational, not medical, and was open to Active Duty Family Members only. The current rates were never intended to set the standard for a medical benefit since they were not based on any study of the nationwide rates. The revised rates make ABA reimbursement more consistent with the basic TRICARE benefit used for all other TRICARE services.

The RAND Corporation's study was the first study commissioned as discussed with the autism advocates and providers. Both groups fully supported using RAND. That study provided calculations of the "average" reimbursement rates for ABA services. The researchers calculated the average rates by developing weighted averages of Medicaid and private insurance payments in each state for which data were available. RAND's report found Medicaid and commercial rates to be very similar in many states.

RAND's study was very well researched and prepared, but multiple changes were subsequently made across the nation as the States adopted or adjusted their autism programs and rates. For that reason, we commissioned the Kennell and Associates, Inc., study to collect more current data while still incorporating data from the

RAND study as appropriate. Thus, the Kennell study can be seen as an update and expansion of the RAND study. Based on the two studies, Kennell proposed four options for setting “National Rates.” The National Rates are adjusted to calculate the locality rate for each of Medicare’s 89 localities. We and the Kennell team worked closely with the RAND researchers to further research several data points needed to establish rates.

- (1) The RAND report did not include data for providing one-on-one ABA services by doctoral or master’s level providers (billing codes 0364T and 0365T) or for family adaptive treatment guidance (code 0370T). Billing codes 0364T and 0365T are the codes most often used as they are billed when providing one-on-one services to the child. Kennell added data for these additional services which are very important to our beneficiaries.
- (2) The RAND report used Medicaid data collected in late 2014 or early 2015. Since that time, many states either adopted or adjusted rates. We are currently adjusting the rates again based on 11 more states, for a total of 35, having adopted or adjusted Medicaid rates since October 2015.
- (3) For one-on-one direct ABA services, RAND did not provide rates for bachelor’s degree providers separate from those with less than a bachelor’s degree. The TRICARE benefit is based on the “tiered model,” allowing services from doctoral and master’s level behavior analysts and supervised bachelor’s level assistant behavior analysts and behavior technicians. Thus, Kennell added these rates.
- (4) The commercial rates obtained by RAND paid for direct, one-on-one ABA services, by type of provider, are currently not available because the MarketScan data used by RAND does not distinguish between the four ABA provider types. Thus, any average rate paid by commercial plan would tend to understate rates paid to doctoral and master’s level behavior analysts and overstate rates paid to supervised bachelor’s level assistant behavior analysts and behavior technicians. This is a problem for services like direct, one-on-one ABA that are provided by a broad range of provider types, especially because the rates often vary substantially by type of provider.

26. Senator GILLIBRAND. Dr. Woodson, the Medicaid plus 20 percent rates are significantly lower for bachelors level and high school level ABA therapy providers than the current rates. For example, bachelors-level providers would be paid \$15 less per hour than they currently earn. How do you justify such a significant cut in reimbursement?

Dr. WOODSON. The revised rates were calculated to reimburse the four provider types (e.g., doctoral and master’s level behavior analysts and supervised bachelor’s level assistant behavior analysts and behavior technicians) at rates appropriate for their education and based on two studies of the nationwide rates for ABA services. The current rates were not set based on a study of the rates when they were adopted 7 years ago. The current rates were set in 2008 under the Extended Care Health Option Enhanced Access to Autism Services demonstration program as an educational program, not medical, for Active Duty Family Members only. The current rates were never intended to set the standard for a medical benefit, since they were not based on any study of nationwide rates. The two recent studies were completed to formally establish a reliable, competitive rate methodology that applies to all locations, with rates calculated for each locality and annually adjusted like all other TRICARE rates. This rate methodology will be used until Medicare establishes ABA rates, which by law, TRICARE will immediately adopt.

The 2016 ABA rates (recalculated this week based on 11 more states adopting or adjusting their rates since October 2015) reimburse bachelor’s level assistants for one-on-one services with a range of \$63.76 – \$91.56 per hour, compared to the current \$75.00 per hour. No rate is being reduced by \$15.00 or more for bachelor’s level assistants and some will actually see an increase. Overall, the ABA rates are consistent with those paid to other mental health providers with similar levels of training. There are no other bachelors level providers reimbursed for mental health services; however, we can compare rates paid to masters and doctoral level ABA providers with those paid to other doctoral level mental health providers. As a comparison, the revised 2016 ABA rates pay a range of \$106.26 to \$132.60 per hour for doctoral and master’s level providers. These rates are actually above what doctoral clinical psychologists are paid nationwide for individual psychotherapy 60-minute sessions (range from \$93.00 to \$105.00). Based on the external studies we commissioned, as well as comparable rates in other mental health fields, we continue to conclude the revised 2016 ABA rates are very competitive.

27. Senator GILLIBRAND. Dr. Woodson, you also stated that “to ensure that in fact we won’t negatively impact services, we reviewed network adequacy almost on a monthly basis and certainly very frequently. We’ll be monitoring this situation very closely. Should we find, in fact, in any locality that has been adversely affected, we will make rapid changes.” How have you been tracking access to and availability of ABA services?

Dr. WOODSON. My Autism Team meets at least twice per month with our three TRICARE Regional Offices and the Managed Care Support Contractors (MCSCs). During each of the calls, the MCSCs provide a summary of the beneficiary waiting lists, if any, and the status of their provider networks. Historically, the concept of “wait lists” has been a concern as providers report long waiting lists, when in actuality; most beneficiaries have found other providers and are not subsequently removed from the wait list. The team discusses the localities of concern based on the waiting list or any pending provider loss due to a clinic closing for any reason (e.g., provider relocation, retirement, etc.). The Military Services’ “Exceptional Family Member Program” representatives also join the conference call to ensure they remain abreast of the available providers and to report any problems they have heard from beneficiaries regarding access to ABA services. To date, our MCSCs have been very successful placing the children on waiting lists with other providers, although some parents choose to wait for particular provider or specific time of day for services.

The TRICARE network of providers is robust overall; however, there are some areas in the country with a limited number of providers similar to many other specialties, such as Alaska, parts of Georgia, Southern California, Seattle-Tacoma, Ft. Leonard Wood, Missouri, and Ft. Riley, Kansas. These are areas with very few providers in the community, and access in these areas is challenging whether the child has commercial insurance, Medicaid, or TRICARE. TRICARE’s three MCSCs are continuously working to recruit new ABA providers for underserved areas to improve access. For example, our MCSCs have successfully recruited additional providers to Ft. Leonard Wood, Missouri; Luke Air Force Base, Arizona; Southern California; the Gulf Coast (i.e., Biloxi, Mississippi to Tampa, Florida); Ft. Campbell, Kentucky; and many other locations, which benefit all children in the community, not just those with TRICARE. We currently have over 23,500 ABA providers, including over 450 new providers since the new rates were released.

Most importantly, please know that we are committed to ensuring every military child with the Autism Spectrum Disorder (ASD) diagnosis has access to the care they need, including ABA. The TRICARE MCSCs will always use the network providers whenever possible to enhance that relationship with “our” provider network partners and be most cost efficient. However, if a network provider is not available, the MCSCs will arrange for care with non-network providers until a network provider is available. This is the same process used to locate providers for all TRICARE Prime enrollees needing a specific provider of any type.

28. Senator GILLIBRAND. Dr. Woodson, based on the reviews you have completed on network adequacy, have you seen any issues with access to ABA therapy and if so, what kind of issues?

Dr. WOODSON. The TRICARE network of providers is robust; however, there are some areas in the country with a limited number of providers whether the child has commercial insurance, Medicaid, or TRICARE. In particular, there are a limited number of ABA providers around military installations in Alaska, parts of Georgia, Southern California, Seattle-Tacoma, Ft. Leonard Wood, Missouri, and Ft. Riley, Kansas.

TRICARE’s three Managed Care Support Contractors (MCSCs) are continuously working to recruit new ABA providers for underserved areas to improve access. For example, our MCSCs have successfully recruited additional providers to Ft. Leonard Wood MO, Luke Air Force Base AZ, Southern California, the Gulf Coast (Biloxi MS to Tampa FL), Ft. Campbell KY and many other locations, which benefits all children in the community, not just those with TRICARE. We currently have over 23,500 ABA providers, including over 450 new providers who have joined TRICARE since the new rates were released on December 3, 2015.

Most importantly, please know that we are committed to ensuring every military child with the Autism Spectrum Disorder (ASD) diagnosis has access to the care they need, including ABA. The MCSCs will always use the network providers whenever possible to enhance that relationship with “our” provider network partners and be most cost efficient. However, if a network provider is not available, the MCSCs will arrange for care with non-network providers until a network provider is available. This is the same process used to locate providers for all TRICARE Prime enrollees needing a specific provider of any type.

As a last resort, for areas chronically underserved by ABA providers, the military Services also carefully work the assignments for Active Duty servicemembers with children needing ABA services to ensure they are not transferred to a location with services limited or not available. The military Services can also transfer a family with a newly diagnosed child needing ABA services (or any other specialty service), to another location if necessary to ensure the needed services are available.

While our contractors deserve a lot of credit for their recruitment efforts, another factor contributing to our robust ABA provider network is that the TRICARE benefit is one of the best in the nation. That is especially true since providers never have to collect a copayment, deductible, or any other payment from Active Duty families, who have 100 percent coverage. Our TRICARE beneficiaries, to include our retired beneficiaries, do not have to make a decision on whether to forego needed care due to affordability, unlike most Americans who may owe copayments or a cost share for each service received.

29. Senator GILLIBRAND. Dr. Woodson, how do you intend to quickly and robustly respond to any indications that children are losing access to needed ABA therapy?

Dr. WOODSON. Most importantly, please know that we are committed to ensuring every military child with the Autism Spectrum Disorder (ASD) diagnosis has access to the care they need, including ABA. The TRICARE Managed Care Support Contractors (MCSCs) will always use the network providers whenever possible to enhance that relationship with our provider network partners and be most cost efficient. However, if a network provider is not available, the MCSCs will arrange for care with non-network providers until a network provider is available. This is the same process used to locate providers for all TRICARE Prime enrollees needing a specific provider of any type.

The military Services also carefully work the assignments for Active Duty Service members with children needing ABA services to ensure they are not transferred to a location with services limited or not available. This applies to both families needing ABA services or any other specialty care for a family member. The military Services can also transfer a family with a newly diagnosed child needing ABA services (or any other specialty service), to another location if necessary to ensure the needed services are available.

As a result, although I do not anticipate any loss of access to ABA services, we stand ready to respond quickly to ensure every child has an ABA provider.

ECHO BENEFIT

30. Senator GILLIBRAND. Dr. Woodson and VADM Bono, I have heard from advocates that military families who are eligible for MEDICAID services have to reapply for MEDICAID benefits every time they move to a new state, and many encounter waiting lists that are longer than their assignments. To address this, the Military Compensation and Retirement Modernization Commission recommended that the Extended Care Health Option (ECHO) benefit be expanded to provide benefits similar to the MEDICAID benefit. What steps have you made to implement this recommendation?

Dr. WOODSON and VADM BONO. We believe that providing effective support for military members with family members who have special needs improves beneficiary satisfaction and supports overall readiness. In collaboration with the Military Compensation and Retirement Modernization Commission (MCRMC) research team, the Defense Health Agency (DHA) developed five goals related to the Commission's recommendations: (1) identify gaps between current ECHO provided services and MEDICAID waiver programs; (2) evaluate the expansion of ECHO respite care and the provision of incontinence supplies (e.g., adult diapers); (3) conduct an investigation into the requirements for providing custodial care; (4) identify those MEDICAID waiver services that would create value for ECHO beneficiaries; and, (5) identify requirements and costs associated with a consumer directed care program. The DHA has already implemented a policy change to allow ECHO beneficiaries to receive personal incontinence supplies. This benefit, which became effective on October 1, 2015, is available to any ECHO beneficiary over age 3 who is incontinent as a result of spinal, neurological, or mobility issues. Working with the MCRMC research group, we are also continuing with an assessment of gaps between ECHO and state MEDICAID waiver programs which provide non-medical services for individuals who would otherwise be institutionalized. We have also worked side-by-side with the MCRMC group to investigate custodial care and consumer-direct care, analyzing the requirements and potential costs by collaborating with civilian health experts and federal programs that currently offer these benefits. We will use this information to conduct a survey (scheduled for June 2016) to better ascertain bene-

fiary needs and determine which MEDICAID services would bring value to ECHO beneficiaries. The results of this survey will shape future ECHO benefit revisions.

LAB DEVELOPED TESTS

31. Senator GILLIBRAND. Dr. Woodson, in 2014, this committee gave you the authority in the Fiscal Year 2015 National Defense Authorization Act to cover emerging health care services and supplies, including Lab Developed Tests (LDTs) when ordered by physicians in the civilian provider network. These tests play a critical role in the diagnosis and treatment of disease, and include tests for Fragile X syndrome, Cystic Fibrosis, Spinal Muscular Atrophy, and many common cancers. What has DHA done to implement this authority?

Dr. WOODSON. Prior to the Fiscal Year 2015 National Defense Authorization Act that allowed authority to cover emerging health care services and supplies, the Defense Health Agency initiated a demonstration project on September 4, 2014, to evaluate non-FDA approved LDTs for TRICARE coverage. Utilizing this separate demonstration authority, the project was started to evaluate the feasibility of establishing a cost-effective and efficient way to review non-FDA approved LDTs. Since the demonstration began 73 LDTs are now covered, to include tests for cancer diagnosis, cancer risk, cancer treatment, blood or clotting disorders, genetic diseases or syndromes, and neurological conditions. Tests for Fragile X syndrome, Cystic Fibrosis and Spinal Muscular Atrophy are specifically covered. As of February 15, 2016, 101,340 beneficiaries have had LDTs completed under the demonstration and over \$49M in claims have been paid.

Section 704 of the NDAA for fiscal year 2015 provided the DOD with authority to extend provisional TRICARE coverage for an emerging healthcare service or supply. The ASD(HA) may authorize provisional coverage if the service or supply is widely recognized in the U.S. as being safe and effective but it does not yet meet the TRICARE standard for proven effectiveness. Surgical treatment for Femoroacetabular Impingement Syndrome (FAI) is the first emerging treatment to be given provisional coverage under the authority in Section 704. The Defense Health Agency (DHA) is currently evaluating several other potential treatments and technologies for provisional coverage focusing on those being done in Military Treatment Facilities but not covered by TRICARE. The DHA has engaged with Service consultants, specialty leaders, and clinical subject matter experts to assist in the evaluation process. A public announcement will be made when additional emerging treatments and technologies are approved for provisional coverage.

32. Senator GILLIBRAND. Dr. Woodson, DHA announced a demonstration project, to begin in September 2014, to evaluate laboratory developed tests (LDTs) for coverage by the TRICARE program. However, LDTs that have been approved for coverage by the demonstration project still remain on the No Government Pay Procedure Code List with no indication that they have been approved for coverage. Why are these tests still on the government no-pay list?

Dr. WOODSON. The specific LDTs that are covered by TRICARE under the LDT demonstration are listed in the TRICARE Operations Manual, Chapter 18, Section 17, and easily accessible to the public. Codes for LDTs payable under the demonstration are still listed on the No Government Pay Procedure Code List (NGPL) because these non-FDA approved LDTs are not covered under the TRICARE Basic Program. The fact that a demonstration-approved LDT remains on the NGPL is specifically discussed in Section 17 and should have no adverse impact on reimbursement under the demonstration.

Through meetings and letters, we have explained to the American Clinical Laboratory Association and our lab partners why LDT codes covered under the demonstration are on the NGPL and where to find the specific LDTs that have been approved for coverage under the demonstration. Codes that appear on the NGPL list are there because TRICARE statute, regulation, or policy has established that procedure as excluded under the TRICARE Basic Program. The NGPL does not represent an exhaustive list of all services that may be denied under the Basic program. Conversely, the fact that a code is not listed does not imply or guarantee coverage. It is critical to utilize the TRICARE statute, regulation, and policy as the authoritative sources of TRICARE coverage and benefit policy, not the NGPL. In addition, there may be other policy and special program provisions such as demonstration programs and the Extended Care Health Option program that affect listed codes, coverage, and reimbursement. Explicit processes within the TRICARE system allow specific codes to be paid under these special programs even though they appear on the NGPL.

33. Senator GILLIBRAND. Dr. Woodson, under the demonstration project, why has DHA established exceedingly burdensome prior authorization requirements for tests? While appropriate in some circumstances, prior authorization is not standard practice for tests. In the best of circumstances, completing the prior authorization process takes a week or more. Meanwhile, other payers—including Medicare—automate their medical necessity determinations through coverage decisions that allow claim adjudication decisions based on diagnosis codes, whether LDTs are involved or not.

Dr. WOODSON. With the exception of preconception and prenatal Cystic Fibrosis (CF) carrier screening, prior authorization is required for LDTs covered under the demonstration. Prior authorization protects the beneficiary, provider, and laboratory by ensuring the requested test meets the clinical criteria for coverage under the demonstration and the claim paid. TRICARE's contract partners have created processes to facilitate the prior authorization process for providers and laboratories. Prior authorization is a standard process throughout the health industry for many LDTs.

The Centers for Medicare and Medicaid Services National Coverage Policies for common laboratory tests utilize ICD-10 diagnoses codes for automated adjudication of claims. TRICARE also uses the same process for many common laboratory tests. However there is a distinction between routine laboratory tests and LDTs. LDTs are handled differently because they are only recognized for TRICARE coverage under the demonstration. Also LDT results play a critical role in the diagnosis and treatment of diseases such as cancer and genetic syndromes that cause developmental delays or cardiac abnormalities. Prior authorization ensures the requested LDT is being used appropriately within the published coverage criteria.

We acknowledge there were difficulties at the beginning in execution of the demonstration project but our Managed Care Support Contractors (MCSCs) through their continued efforts have tried to make the prior authorization process as simple and easy as possible. We have encouraged our lab partners to work with the MCSCs to address prior authorization concerns and make recommendations for process improvements.

This demonstration was started to evaluate the feasibility of establishing a cost-effective and efficient way to review non-FDA approved LDTs. Prior authorization will be one of the processes evaluated. The DHA wants to find the right balance in ensuring requested LDTs are medically necessary and appropriate and having as streamlined a process as possible from ordering to claim reimbursement.

APPENDIX A



Statement

by the

NATIONAL MILITARY FAMILY ASSOCIATION

for

**Subcommittee on
Personnel**

of the

**UNITED STATES SENATE
ARMED SERVICES COMMITTEE**

February 23, 2016

The National Military Family Association (NMFA) is the leading nonprofit dedicated to serving the families who stand behind the uniform. Since 1969, NMFA has worked to strengthen and protect millions of families through its advocacy and programs. They provide spouse scholarships, camps for military kids, and retreats for families reconnecting after deployment and for the families of the wounded, ill, or injured. NMFA serves the families of the currently serving, retired, wounded or fallen members of the Army, Navy, Marine Corps, Air Force, Coast Guard, and Commissioned Corps of the USPHS and NOAA.

Association Volunteers in military communities worldwide provide a direct link between military families and the Association staff in the Nation's capital. These volunteers are our "eyes and ears," bringing shared local concerns to national attention.

The Association does not have or receive federal grants or contracts.

Our website is: www.MilitaryFamily.org.

The FY17 Administration Budget Health Care Proposal: Where's the Reform?

We appreciate Congress has listened to beneficiary concerns regarding the Military Health System (MHS) and are gratified you want to make the MHS work better for all beneficiaries via military health care reform. We hope the changes Congress enacts will truly make a difference in military families' ability to access the right care, at the right time, and in the right place. Our families deserve no less.

Given Congress' clearly stated objectives for MHS Reform, our Association had hoped the Department of Defense (DoD) budget proposal would outline plans to improve beneficiary access, quality, safety, and the patient experience in addition to addressing fiscal sustainability. Instead, DoD has once again rebranded the same old system, incorporated numerous fee increases, and deemed it new and improved.

While we appreciate DoD's budget proposal has finally acknowledged several areas of deficiency within the MHS including access challenges, lack of first call resolution, a cumbersome referral process, administrative burdens and care delays during Permanent Change of Station (PCS) moves, and pediatric issues, simply cataloging the problems does not constitute institutional reform.

We continue to analyze and will present a detailed response to DoD's budget proposal for the Personnel Posture Hearing on March 8, 2016. In the meantime, this document outlines our expectations for MHS Reform together with a detailed assessment of problem areas that must be addressed to deliver meaningful improvements in military family health care.

The State of the Military Family

For military families, although combat operations in Iraq and Afghanistan have officially ceased, it certainly doesn't feel like the wars are over. Thousands of service members continue to deploy across the globe facing hazardous conditions and lengthy family separations. Looming worldwide threats lead military families to anxiously consider how their service members might be deployed in response. On top of this, our families are also grappling with job insecurity due to military downsizing and financial stress as a result of compensation and benefit cuts. Perhaps most worrisome for today's military families is there seems to be no end in sight to either global military conflicts or threats to their financial security.

Importance of Health Care for Military Families

Affordable and timely access to health care is important to all families, but it is vital for military families. Repeated deployments; caring for the wounded, ill, and injured; the stress and uncertainty of military life; and the need to maintain family readiness demand quality and readily available health care. Families need a robust and reliable health care benefit in order to focus on managing the many challenges associated with military life versus worrying about how they are going to access and pay for essential health care. The military health care benefit must address the unique conditions of service and the extraordinary sacrifices demanded of service members and their families.

Service members and their families consistently rate health care as one of the most valued aspects of the military compensation and benefits package, even as they also share stories of delayed access and confusing procedures. As such, the impact of health benefit changes on recruiting and retention must also be considered as part of MHS Reform.

Why MHS Reform Now?

Our Association believes now is the time to tackle MHS Reform. We agree with the Military Compensation and Retirement Modernization Commission (MCRMC) report that the TRICARE status quo is unsustainable. TRICARE—both the benefit and the system in place to deliver the benefit—faces pressure on multiple fronts and beneficiaries will continue to feel pressure as they access care and in the cost of that care. Specifically, TRICARE's beneficiary satisfaction and fiscal sustainability have both declined. As the FY17 budget proposal makes clear, further dilution of the current TRICARE benefit is inevitable as DoD nibbles around the edges, making incremental changes while increasing beneficiaries' out-of-pocket costs. **We appreciate Congress has made MHS Reform a priority and trust reform efforts will focus on ensuring both the benefit and the system charged with delivering the benefit work better for military families.**

Acknowledgement of Dual Readiness and Benefit Missions

The MHS is unique in that it has dual readiness and benefit provision missions. The MHS readiness mission must achieve both a medically ready fighting force that is healthy and capable of deploying as needed **and** a ready medical provider force capable of delivering health and combat-casualty care for service members in operational environments. The MHS benefit provision mission is to provide the earned health care benefit to family members, retirees, and survivors. The two missions intersect when military medical personnel provide care to family members and retirees in Military Treatment Facilities (MTFs) honing their medical skills in the process.

With our Association's mission and expertise in advocating for military families, we have clear perspectives on how MHS Reform must address beneficiary issues. However, we acknowledge benefit reform efforts must not preclude the MHS from achieving its military medical readiness goals.

Our Association strongly asserts MHS Reform efforts must make a distinction between readiness costs and benefit costs. The MHS budget associated with service member medical readiness, medical provider readiness, wartime operations, and the care of wounded, ill, and injured service members **should not** be included in the cost structure of providing a health care benefit to the children, spouses, and surviving family members of service members and retirees. Our Association believes DoD has not effectively differentiated health care readiness costs from the costs of providing the employer-sponsored benefit. **This failure, we believe, puts both the readiness function and access to care for family members, retirees, and survivors at risk.**

Requirements for Providing the Earned Health Care Benefit to Military Families

The MHS should provide health care on par with that available via high quality commercial plans, tailored to address military families' unique needs, but at a significantly lower cost to acknowledge the value of service. We will consider MHS Reform a success if it achieves the following:

Access to High Quality Care

MHS Reform should ensure military families have ready access to primary care including urgent, routine, and preventative care. Primary care should also include care coordination services as needed. Another requirement is easier access to specialty care. We realize there are medical specialist shortages in many civilian and military communities, particularly among pediatric and behavioral health providers. We don't expect the TRICARE program to work miracles where specialties are scarce, but we do expect robust networks that provide access and choice to the extent possible. MHS Reform must consider service members are ordered to all parts of the U.S. and the world with varying degrees of access to Military Treatment Facilities (MTFs) and civilian medical assets. The MHS must provide military families with access to care regardless of where they live.

The Department of Defense (DoD) has already published Access Standards for Care¹ including urgent care (24 hours), routine care (7 days), and specialty care (4 weeks.) While we believe the Access Standards provide a good benchmark for acceptable access to care, we also note awareness of the standards is low among the beneficiary population and compliance is variable at the MTF level.

Access to care also includes coverage that is appropriate for all beneficiary populations and aligns with the most current medical best practices. MHS Reform must allow coverage policies to evolve with innovations in technologies and treatment protocols and ensure it meets the needs of all beneficiary segments.

We thank Congress for the FY16 NDAA provisions such as the Urgent Care Pilot, provisions to improve access to care and TRICARE portability, and the enhanced MHS reporting requirements that will address some of the current TRICARE problems until systemic reforms occur.

Reliable, safe, high quality care across both the Direct and Purchased Care systems is non-negotiable. Quality and safety must be measured and monitored to ensure military families are receiving the best possible medical care.

Policies Designed to Address the Unique Challenges of Military Service

The MHS must be designed to facilitate the transition of care for a mobile population. MHS Reform must identify and fix areas where the current system exacerbates disruptions in care necessitated by Permanent Change of Station (PCS) moves. With MHS Reform, families should be

¹ TRICARE Policy for Access to Care/HA Policy: 11-005

able to seamlessly transfer prescriptions and existing specialty care, including OB services, to new pharmacies and providers without delay.

MHS Reform must also consider issues associated with deployments and family separations. The benefit must work for families who are geographically separated. It must also provide enhanced coverage for mental health and other conditions caused or exacerbated by the extraordinary stress families experience during deployment.

Costs that Acknowledge the Value of Service

We reject the notion that health care is “free” for military families. While military families may not pay monthly premiums, deductibles, or co-pays under TRICARE Prime, service members earn the benefit by way of the extraordinary demands, risks, and sacrifices associated with military service. Comparisons with civilians’ out-of-pocket costs, while helpful in assessing the military health benefit’s value, are largely irrelevant when determining fair out-of-pocket costs for military families.

We appreciate that past DoD proposals have not included increased TRICARE costs for active duty and their family members. We also appreciate DoD’s assurance that any proposed TRICARE enrollment fee changes will not apply to medically retired service members and survivors. MHS Reform must continue to adhere to these principles.

Our Association has always been open to introducing a mechanism for modest cost increases for retirees and is willing to engage in conversations about appropriate fee levels and additional MHS efficiencies. However, we believe out-of-pocket expenses for retirees must be contained to avoid diminishing the value of the earned retirement benefit.

Areas to Consider with MHS Reform – What’s Working?

MHS Reform should maintain or expand upon areas that are currently working for beneficiaries, including:

- **Access to Care in Certain Areas:** Health care is local, so access problems vary by location. There are some MTFs and TRICARE network areas where families are satisfied with their access to care.
- **Pockets of Excellence Within the Direct Care System:** Beneficiaries in some areas tell us they receive exceptional care at their MTFs. MHS leaders must ensure best practices within the system are identified and widely disseminated.
- **Mental Health and Applied Behavior Analysis (ABA) Coverage:** TRICARE has tailored coverage in these areas in recognition of military families’ unique needs. Mental health care is available without referral and at zero out-of-pocket cost. As some military families struggle to cope after 14 years of war, it is vital these policies continue. DoD has also enhanced ABA coverage to meet the needs of family members with autism. Current ABA coverage is the result of years of deliberation, research investigation, and pilot program

evaluation. The resulting coverage levels DoD has deemed appropriate for military families must remain linked to high-quality, evidenced-based practices in the future.

- **Current Beneficiary Costs:** Current low out-of-pocket costs reflect the value of service while catastrophic caps protect military families from potential financial hardship related to medical expenses. Given the extraordinary risks service members assume during the course of military service, we believe it is appropriate to protect them from financial risk wherever possible.
- **U.S. Family Health Plan (USFHP):** USFHP beneficiaries express high satisfaction with the program. They appreciate assistance from Care Managers so they do not have to navigate the system on their own. They have access to robust provider networks. Military families using USFHP benefit from wellness, prevention, and disease management programs as well as provider outreach to enhance communication. All of these programs result in better health care outcomes. Compared to TRICARE Prime enrollees, USFHP participants have 33% fewer inpatient days and 28% fewer emergency room visits.²

What's not working? Access to Care Issues

Access to care is the broadest area of concern and takes many forms, including:

Direct Care Acute Appointment Shortages

For years, our Association has advocated for better access to urgent care. When military families call the MTF to make an appointment for a sick or injured family member, too many are told there are no appointments available. Too many are told they cannot get a referral to an urgent care in the community. Too many are left with the Emergency Room as their only option for treatment of acute medical problems such as ear infections and strep throat – conditions that aren't emergencies, but must be treated promptly.

In late 2015, our Association fielded a survey of 4,010 military spouses. Nearly 30% of respondents who use an MTF for primary care indicated they rarely or never get an acute appointment within the 24 hour access standard. This is consistent with findings from a health care survey fielded by the Military Officer Association of America (MOAA) in December 2015 in which 29% of active duty spouses reported they rarely or never get an acute care appointment within access standards.

Military families lead complicated lives rife with uncertainty. Obtaining health care for sick or injured family members should not be complicated or uncertain.

In April 2015, NMFA conducted an Acute Care Campaign via social media. Our goal was to demonstrate the breadth of acute care barriers as well as illustrate how access challenges impact military families. Over the course of the campaign, we engaged thousands of beneficiaries in a dialog and collected 131 stories about acute care access problems. With a worldwide network of Volunteers, frequent engagement with the military community, and our own experiences as

² Final Report of the Military Compensation and Retirement Modernization Commission – January, 2015

military family members, we are able to differentiate common themes versus unique situations. Stories collected during our outreach campaign highlight how difficult it is for many families to access the right care, at the right time, in the most appropriate setting. Specific findings include:

- **Military families recognize their Primary Care Manager (PCM) is the best source for care when they are sick or injured.** As a recent DoD Health.mil article (*Pediatricians Serve as Important Resources for Parents*) points out, pediatricians have specialized training and skills versus general practitioners and parents understand this. Continuity of care is also important to military families.

"Military families would vastly prefer not to be sent to the ER or urgent care. Not only is it more expensive for the military when this happens, but it interrupts patient care and continuity and does not provide the best care for our families." (Military Spouse)

- However, **military families face a variety of challenges in obtaining timely acute appointments with their direct care PCMs/pediatricians.** When families call for acute appointments, they are often told:
 - The next appointment is days or weeks away, so no appointment is made and families are left to determine appropriate next steps
 - To call back the next day
 - To go to the ER
- When a PCM/pediatrician appointment is unavailable, **military families often face confusing, inconsistent policies for obtaining network urgent care referrals.**
- **Most military families would prefer to avoid the ER, but often find it is their only option for care.** They are frustrated by the inconvenience and delay in care resulting from ER use.
- **Military families experience delays in follow up specialty care when they can't be seen by their PCM/pediatrician.** TRICARE doesn't accept referrals from ER or Urgent Care providers necessitating an additional visit with a PCM just to get the recommended referral.

Other MTF Appointment Issues

- **Routine Care Scheduling Challenges:** Families report delays in scheduling preventative, routine, and follow up care.
 - In NMFA's military spouse survey, 31% of MTF users said they rarely or never get a routine appointment within the 7 day access standard.
 - 42% of active duty spouses in MOAA's health care survey said they rarely or never get routine appointments within access standards.
- Not only are some families unable to schedule routine appointments within a reasonable time frame, but the **process for scheduling is cumbersome.** Families are often required to call the

appointment line multiple times in the hopes of finding an opening within the currently available appointment book. We appreciate DoD has started to take steps to remedy this problem, but we believe routine appointment availability should still be examined during MHS Reform discussions.

- **Impact of Recapture Efforts on Appointment Scheduling:** While we support DoD's efforts to recapture care back into the direct system to better utilize existing capacity and fixed assets, we fear some MTFs may be overreaching leading to access problems. We have also seen questionable referral decisions that seem to be driven by specialty care recapture. For instance, families stationed at MCB Quantico have been told they must receive physical therapy at Walter Reed National Military Medical Center. Travel time from Quantico to Walter Reed only meets the one hour drive time access standard under the most optimal conditions. Restricting appointments to Walter Reed effectively creates a barrier to accessing necessary physical therapy for Quantico families.

Please note MTF access problems are not exclusive to family members. We regularly hear about service members who are unable to get timely appointments. We recently talked to a service member with a foot injury. When he called to schedule an appointment, the next available opening was five weeks away. **Failure to provide timely care to service members is a readiness issue.**

Cumbersome Referral and Authorization Process:

The referral and authorization needed to obtain network specialty care can result in delays and disruptions to care. Many families report problems with referral processing. These issues become more pronounced during PCS moves. Military families recognize continuity of medical care is one of the sacrifices they must make as a result of the highly mobile military lifestyle. Unfortunately, many TRICARE and MTF policies hinder rather than facilitate the smooth transition of care during PCS moves. For instance, specialty care requires a new referral and authorization in the new location while patients are often required to reconfirm an existing diagnosis before seeking treatment.

"I can't tell you how many times that when we did get referrals they were for the wrong sort of service because that's just who came up first in the system with no regard to sub-specialty." (Military spouse)

"PCMs should be able to transfer referrals across TRICARE regions. My example: My daughter was diagnosed with moderate scoliosis in May 2013. We PCS'd in June and had to start the process all over once we settled into our new location. By the time we had all the required referrals and seen all the appropriate specialists, we had wasted almost four months waiting for treatment. She finally got her back brace on October 1, and her curve had progressed significantly." (Military spouse)

Difficulty Accessing Coverage While Traveling

It is imperative families have access to urgent care while traveling. It is unacceptable the Emergency Room is the only option for care for military families who are traveling or en route

during a PCS. We appreciate the Urgent Care Pilot included in the FY16 NDAA and hope DoD's implementation allows urgent care visits while military families are away from home.

"Traveling through states during a PCS move when your child needs to see a doctor is a nightmare. My daughter had an eye infection when we were traveling and stopped in the Midwest from NC to CA. The only option was the ER since we were not in our Tricare region. I spent hours on the phone with Tricare and my PCM from my previous state to get a referral so my daughter could be seen in a clinic. It was like pulling teeth from everyone right down to getting a prescription. Plus the time changes with offices made it difficult. It took 2 days and countless time on the phone between Tricare and the doctor's office. I felt helpless and angry having to fight for care for my 1 year old." (Military spouse)

Purchased Care Access Issues

- **Areas with TRICARE Network Inadequacy:** In some areas, families complain there is a shortage of providers in the network and those listed often are no longer accepting new TRICARE patients. We fear this problem will become worse as the Affordable Care Act and Medicaid expansion increase the demand for medical providers.
- **Behavioral Health Provider Shortage:** One of the consequences of 14 years of war is increased demand for mental health services which continues to outstrip supply. MHS Reform must explore innovative solutions, including greater coordination between the military and civilian provider base, to address this problem.
 - Data from NMFA's spouse survey and MOAA's health care survey indicate alarming rates of behavioral health usage among military families. These studies show that between 40-50% of military spouses have sought behavioral health care for someone in their family.
 - TRICARE utilization data also indicates high levels of behavioral health care use. TRICARE Prime beneficiary behavioral health utilization was 54% higher than the corresponding rate for civilian HMOs in FY14. The TRICARE report hypothesizes this disparity reflects the more stressful environment many active duty service members and their families endure³.
 - We recognize there is a national shortage of mental health providers. While TRICARE contractors have expanded their behavioral health provider networks to help meet demand, military families in some areas continue to report provider shortages, especially for psychiatric care for children and teens.

³ Evaluation of the TRICARE Program FY2015
<http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program>

What's Not Working? Quality and Coverage Issues

Direct Care System

- **Variable Quality and Safety:**
 - We are concerned DoD's 2014 MHS Review of quality measures showed mixed results with considerable variation across the system for both specific clinical measures and for individual MTFs. This is consistent with feedback we hear from military families. Some are very pleased with their MTF care while others relay stories that clearly demonstrate quality and safety issues. We appreciate DoD has launched a High Reliability Organization initiative. **MHS Reform must ensure continuous improvement efforts are consistently integrated across the entire Direct Care system.**
 - Another finding of particular concern involved follow up on sentinel events. The MHS Review found the execution and content of root cause analysis (RCA) to understand the possible causes of adverse health events related to care (sentinel events) remains highly variable across the Services and MTFs. In addition, there has been a failure to routinely follow up on reported RCAs to ensure systemic issues identified were corrected. **Failure to follow up on sentinel events is unacceptable.**⁴ We have asked how this is being addressed and have not received any information.
- **Beneficiary Quality Perceptions:** Military family members feel care is compromised by provider turnover/lack of continuity of care, inadequate appointment length, and direct care providers who don't listen or review patient medical history.

"We left the Prime system and switched to standard because there was high doctor turnover in our military clinic leading to poor patient care." (Military spouse)

"I went to see my doctor for back pain and he asked me if I wanted to discuss the upper back or lower back. We couldn't talk about both. I had to make a second appointment." (Military spouse)
- **Inconsistent Policy Implementation at the MTF Level:** MTF Commanding Officers have a great deal of authority when it comes to setting policies at their facilities. While this is understandable given the complexity of the MHS and the unique conditions of each location, the existence of policies that vary from one MTF to another can make it even harder for military families to effectively navigate the system. Inconsistent policies for referring patients to TRICARE network urgent care is one of the most common examples. Another recent example we've heard relates to TRICARE's new Lactation Supplies and Support Policy. To its credit, DoD introduced the policy with an integrated communications plan including a Facebook Town Hall to answer beneficiary questions. The policy very clearly stated there were no restrictions on when an expectant or new mom could purchase a TRICARE covered breast pump. We've subsequently learned Landstuhl Regional Medical Center implemented the policy with a

⁴ Military Health System Review Final Report to the Secretary of Defense -- August, 2014

restriction. LPMC OBGYN will only provide the necessary breast pump prescription/order at 38 weeks. It is discouraging DoD's strategic communications plan to educate military families about the new policy is undermined by inconsistent implementation at the MTF level.

- **Poor Communication:** Families complain about difficulties in obtaining lab results, errors in medical records, and providers' failure to return phone calls. Similar to access, communication quality varies across MTFs. For instance, when the Direct Care recapture rolled out, affected families from Madigan Army Medical Center at Joint Base Lewis-McChord received a letter welcoming them back to the MTF together with a pamphlet highlighting the advantages of being seen at Madigan. Madigan also had a Patient Advocate specifically designated to field beneficiary questions about the recapture. Contrast this with the way the recapture was handled at Womack Army Medical Center at Fort Bragg. Affected patients received a post card alerting them to a Primary Care Manager (PCM) change with no further explanation. When we called Womack, the Patient Advocate could not answer our questions about the recapture waiver process, but made it clear we should not send families to her.
- **Lagging Customer Service Innovations:** DoD is slow to adopt Customer Service innovations, such as the Nurse Advice Line (NAL) and Secure Messaging. New program rollouts often lack patient focus. While DoD has analyzed the NAL's business impact, it has not to our knowledge surveyed users to ensure the service meets beneficiary needs. Although Secure Messaging aligns with young military families' preferred communication methods, adoption rates have lagged. We suspect this is linked to implementation issues such as the wide variety of names for the system (Relay Health, MiConnect, Medical Homeport Online, Army Medicine Secure Messaging and simply Secure Messaging) and inconsistent MTF, clinic and provider adoption.

Purchased Care

- **TRICARE Slow to Cover Emerging Technologies and Treatment Protocols:** Health care is in a period of rapid change and innovation. Since TRICARE coverage policies are governed by statute, they are difficult to update to cover new technologies. As a result, TRICARE beneficiary care lags that of civilians. Military families who receive care at MTFs have better access to health care innovations, since the rules governing MTFs are less stringent than TRICARE's regulations. We appreciate Congress gave DoD the authority to cover emerging technologies in the FY15 NDAA. However, DoD seems reluctant to exert that authority. In the case of Lab Developed Tests (LDTs,) TRICARE still covers only a fraction of tests available via commercial plans, Medicare, and Medicaid.

Earlier this year, the family of an Active Guard Reserve (AGR) soldier in Indiana contacted us for help in obtaining a diagnostic genetic test (an LDT) for their son. His doctors believe he may suffer from a rare genetic syndrome and recommended the test to inform their treatment decisions and better understand the child's prognosis. TRICARE denied coverage. After many months, we were eventually able to help the Indiana family obtain the test at Walter Reed. The family traveled from Indiana to Maryland for a blood draw. The baby's blood sample was then sent to a commercial laboratory in Wisconsin for testing. Since the testing was done as a "courtesy," the family doesn't have access to the genetic counseling and possible future genetic

testing necessary to determine next steps. MHS Reform must address this issue to ensure military family medical treatment evolves to include new technologies and treatment protocols.

- **Customer Service Issues:** The contracting process leads to regular Managed Care Support Contractor (MCSC) turnover. These changes rarely go smoothly and the result is customer service disruptions for military families. In some cases, where referral/authorization processing was disrupted, it has even affected access to care. TRICARE's T17 contracts will move to two TRICARE Regions resulting in an inevitable MCSC transition for many TRICARE beneficiaries.

What's Not Working? Lack of Metrics, Benchmarks, Accountability, and Oversight

- DoD and GAO reports consistently highlight the lack of high quality metrics leading to an inability to evaluate military health system performance. Without proper metrics, it will be impossible to monitor progress against MHS Reform goals.
 - The 2014 MHS Review identified a major gap in the ability of the MHS to analyze system-wide health care information. It also observed there is no mechanism to recognize patient input making it difficult to act on feedback from patients regarding their needs. We noted MHS metrics utilized in the report are sometimes incomplete or misleading. For instance, DoD's access measure indicates the average wait time for an acute appointment is 0.97 days, outperforming access standards. However, that metric only measures the timing of actual appointments scheduled. It does not capture suppressed demand or those patients told to call back or go to the Emergency Room because no appointments were available.
 - DoD's *Study on Health Care and Related Support for Children of Members of the Armed Forces* acknowledges a lack of common data evaluation systems or metrics within DoD or the Military Departments to evaluate the programs that support the physical and behavioral health care needs of children. Throughout the report, conclusions are drawn on limited and largely irrelevant data. Although the report "concludes the MHS is meeting the needs of the children in its care, including those with special needs," we believe a more accurate conclusion is MHS has inadequate data to evaluate access to pediatric care in appropriate settings.
 - Most recently, the GAO released a report on the TRICARE Pharmacy Pilot. GAO concluded DoD has not fully monitored the pilot's performance and thus does not know whether it is working as intended. We agree with the GAO that this information would be beneficial given the expansion of the pilot requirements to all beneficiaries.
- Our Association finds it discouraging that even legislative fixes are not guarantees of MHS improvement. DoD frequently cites Section 704 from the FY15 NDAA granting them authority for provisional TRICARE coverage for emerging health care services and supplies. Yet they have failed to exert that authority to make coverage improvements. Section 735 of the FY13 NDAA required not only a study on pediatric care for military-connected children, but also a plan to improve and continuously monitor military kids' access to care. Since the study's release in July

2014, DoD has released minimal information regarding next steps. DoD's seeming inability to move forward in a timely manner and engage in transparent communication lowers stakeholder and beneficiary confidence that improvements are possible.

Special Populations to Address with MHS Reform

- **Reserve Component Families:** National Guard and Reserve families are poorly served with their current TRICARE options. When activated, their families become eligible for TRICARE, but coverage and network providers may not align with their civilian plans. This leads to confusion and disruptions in care as families switch to providers in the TRICARE network. We have long advocated for more flexibility in allowing Reserve Component families to retain their employer sponsored plan when activated, perhaps by paying them a stipend to help cover premiums. We believe MHS Reform does not have to be a "one size fits all" solution. TRICARE coverage should be tailored to meet the unique needs of Reserve Component families.
- **Maternity/OB:** The military has a large population of young families, so it is not surprising that inpatient procedures at military hospitals are predominantly related to pregnancy, childbirth, and newborn care.⁵ MHS Reform must not only ensure safe, high quality care for our expectant moms, it must also address the unique challenges associated with the military lifestyle.
 - **Quality:** The MHS Review noted inconsistent performance on maternal and neonatal birth outcome measures with higher rates of maternal hemorrhage and undefined neonatal trauma than the national average.
 - **Provider Consistency:** Our informal military maternity care survey revealed moms are largely satisfied with the care they receive. The most frequently cited complaint about military maternity care is the lack of provider consistency. Respondents were uncomfortable with seeing a new provider at each appointment. They feared the lack of continuity compromised the quality of their care. These concerns were even more prevalent among moms who had a previous birth experience in a civilian facility with greater provider consistency.

"I would say of the three birth experiences I had, the two in civilian hospitals were my best. Not that the military facility was bad but it really does make a huge difference when you get to see the same doctor throughout the entire pregnancy. With my first at Tripler Army Medical I think I saw 9 different doctors and had never seen the one who delivered me. Just felt very impersonal and a bit frustrating having to retell situations or issues since they were not with me from the beginning." (Military spouse)

⁵ Final Report of the Military Compensation and Retirement Modernization Commission – January, 2015

- **PCS:** The MHS must facilitate the transition of maternity care following a PCS to allow the expectant mom to follow the recommended prenatal care schedule.
 - Unfortunately, Direct Care policies and appointment shortages can slow the process. Our Association spoke with a young mother who PCS'd during the 28th week of her pregnancy. She had been identified as high risk by the OB at the losing duty station. Before being assigned to an OB at the new duty station, she had to see her new PCM and take a pregnancy test, despite the fact she had carried her records to verify not only the pregnancy, but also her high risk status. Even after verifying the pregnancy, she could not get an appointment until she was 36 weeks.
 - Transitioning prenatal care to a TRICARE Network provider can present another set of problems. Many civilian OBs are reluctant to accept a new patient after a certain point in the pregnancy. One mom told us she PCS'd toward the end of her pregnancy. She called every OB in the TRICARE directory and nobody would take her as a patient. Finally, one office told her to just show up at the hospital when she went into labor and they would have to deliver her. This is not an acceptable level of care for military families. Expectant moms should have a resource to help them navigate obstacles in re-establishing network prenatal care.
- **Deployment:** The extraordinary stress associated with deployment must also be considered when shaping MHS maternity care.
 - A Fort Bragg doctor recently published a study showing women with a spouse deployed during their pregnancy are at increased risk for preterm birth and postpartum depression.⁶ MHS Reform should consider the option of group prenatal care as it seems to have a positive effect on adverse perinatal outcomes among women with deployed spouses.
 - New moms we surveyed noted the importance of a wireless connection during labor and delivery when their partner is deployed. Most said their MTF lacked wireless. This technology allows the service member to experience the child's birth and support mom even though he or she is not physically present.
- **Special Needs:** Caring for a special needs family member can be difficult and draining for any family. However, the impact for military families is magnified by the unique challenges associated with military service and TRICARE policy. MHS Reform must ensure military special needs families are appropriately supported as they navigate multiple systems of care for their family members.

⁶ Christopher M. Tarney, et al., "Association of Spouse Deployment on Pregnancy Outcomes in a U.S. Military Population", *Obstetrics & Gynecology*, 2015

- **PCS:** Frequent geographic relocations are a fact of life for military families. A PCS will, by definition, disrupt the continuity of care that is so important in managing complex medical conditions. After every move, special needs families must begin a lengthy cycle of referrals, authorizations and waitlists resulting in repeated gaps in care. Military families fear these repeated treatment delays have a cumulative and permanent negative effect on their special needs family members.
- **Case Management:** Families often run into roadblocks when establishing or re-establishing care for special needs family members. When this happens, they need effective case management services to help them navigate obstacles to obtain the needed care and services. Families who contact our Association have no idea where to turn when their existing case managers fail to resolve their problems. MHS Reform should include an evaluation of current case management services to determine if they are meeting military families' needs.
- **ECHO:** For special needs military families, frequent relocation presents another obstacle: the inability to qualify for services through Medicaid waivers. State Medicaid programs provide assistance not covered by TRICARE: respite care, employment supports, housing, and more flexible medical coverage. Because the demand for these services far outstrips the supply, there is a lengthy waiting list to receive assistance in most states rendering them inaccessible to many military families who PCS before reaching the top of the list. TRICARE's Extended Health Care Option (ECHO) was designed to address this imbalance by allowing families to access non-medical services not covered under TRICARE. However, the MCRMC found ECHO benefits, as currently implemented, are not robust enough to replace state waiver programs.⁷ DoD has assured our Association they are working on ECHO improvements. However, other than a policy update to cover incontinence supplies, we have heard none of the specifics. Given the importance of ECHO to special needs families, MHS Reform must examine how to improve ECHO benefits.
- **Transition:** The transition out of the military and into civilian life is difficult for many families, but especially so for special needs families, who immediately lose access to ECHO benefits. Families may still face long waits before being eligible for Medicaid, which leads either to gaps in treatment or financial hardship for a family trying to pay for needed care. As more service members and families transition out of the military, this problem will become more widespread. To ease the hardship for families in this situation, we recommend ECHO eligibility be extended for one year following separation to provide more time for families to obtain services in their communities.
- **Pediatric Care:** The MHS provides care for 2.4 million military kids, but because TRICARE policy is based on Medicare, a program for senior adults, its policies are not always optimal for pediatric care.

⁷ Final Report of the Military Compensation and Retirement Modernization Commission – January, 2015

- **Medical Necessity:** TRICARE's adult-based definition of medical necessity prevents some kids from getting the care they need – care that is widely accepted and practiced in the civilian health care system and MTFs. TRICARE is authorized to approve purchased care only when it is "medically or psychologically necessary and appropriate care based on reliable evidence." DoD's hierarchy of reliable evidence includes only "published research based on well controlled clinical studies, formal technology assessments, and/or published national medical organization policies/positions/reports." While beneficiaries certainly want safe and effective treatment, such tightly prescribed data for children is not always available. TRICARE's strict adherence to this adult-based standard of reliable evidence results in coverage denials for widely accepted pediatric treatments.
- **Well-Child Care:** DoD's *Study on Health Care and Related Support for Children of Members of the Armed Forces* acknowledges TRICARE's pediatric preventative program does not conform to American Academy of Pediatrics (AAP) periodicity guidelines. TRICARE's well-child benefit ends at age 5 (at age 6 beneficiaries are covered under generally authorized clinical preventative services) whereas AAP recommends screening for physical, emotional, and developmental needs to age 21. We believe TRICARE's well-child benefit should align with AAP and Affordable Care Act guidelines, as well as Medicaid's Early and Periodic Screening Diagnostic and Treatment (EPSDT) services.
- **Habilitative Care:** Habilitation services are available only for active duty family members through the ECHO program and are subject to an annual dollar limit of \$36,000. This differs from the ACA which recognizes habilitative services and devices as an essential health benefit without lifetime or annual dollar caps on care. Habilitative services, provided for a person to attain or maintain a skill for daily living, are uniquely necessary for children due to their stages of growth and development. Habilitative services should be covered as a basic health benefit as medically necessary just as rehabilitation services are covered.
- **Medical Nutrition:** TRICARE's definition of medical nutrition is too narrow and counseling and management are only covered as part of diabetic care. TRICARE is not keeping pace with current best practices nationally for specialized pediatric care.
- **Behavioral Health:** More than 14 years of war have left families with behavioral health problems and reintegration challenges that may last for many years. During a recent visit to Fort Bragg, our Association learned Womack's Child and Adolescent Behavioral Health Service refers multiple military children to residential treatment each month. It is a moral imperative to provide service members and their families with the help they need after years of enduring repeated combat deployments. We appreciate the comprehensive revisions to TRICARE mental health coverage outlined in the proposed rule released on February 1, 2016. The updated regulations address several issues we have advocated to change for several years, including:
 - **Removal of TRICARE coverage limits on inpatient mental health services.** We thank Congress for including this provision in the FY15 NDAA.

- **Expanded coverage for intensive outpatient programs:** Intensive outpatient treatment programs have been adopted as a standard practice in the private sector and the Veterans Health Administration. TRICARE, however, has not reimbursed for this care.
- **Streamlined requirements for institutional TRICARE authorized providers:** While TRICARE’s comprehensive certification standards were once considered necessary to ensure quality and safety, these requirements proved to be overly restrictive and, at times, inconsistent with current industry-based institutional provider standards.

Barriers to Improving TRICARE

Our Association is open to discussing a variety of ideas for improving how the health benefit is delivered to military families. We believe now is the time for Congress and DoD to consider a fundamental overhaul of military health care given the barriers to improving the existing TRICARE program, which include:

- **The current budgetary environment**, with an emphasis on cost-cutting and increased beneficiary contributions, is unlikely to yield TRICARE benefit enhancements. Given the pressure to reduce DoD health care spending, we find ourselves repeatedly fighting just to maintain the current benefit. For example, last year we argued against DoD’s Consolidated TRICARE proposal that would have increased beneficiary costs while doing nothing to enhance the benefit for military families. The Administration’s FY17 budget proposal similarly increases beneficiary costs while failing to improve the benefit or suggest meaningful reform. It is unlikely we will realize TRICARE program improvements during a period of fiscal constraint.
- **TRICARE reimbursement policies, governed by statute, are difficult to modernize.** It literally takes an Act of Congress to make substantive changes to TRICARE coverage policy. This means TRICARE is slow to cover new technologies and treatment protocols. As health care continues to evolve, military families will be left with coverage that lags their civilian counterparts.
- **The Military Health System’s dual readiness and benefit provision missions make it difficult to focus on improving the beneficiary health care benefit:** The critical need to achieve readiness (i.e., a medically ready fighting force and a ready medical provider force capable of delivering health and combat-casualty care in operational environments) leads to a lack of focus on the earned health care benefit for family members, retirees, and survivors. When readiness resources are tight, sick kids lose.
- **The Military Health System’s lack of a unified medical command** leads to inconsistent policy compliance by the Services. There is no measure of MTF compliance and no accountability from the MTF to the Service to DoD in regard to policy adherence. Without a

unified medical command, we are skeptical policy improvements would be consistently implemented at the local level.

- **DoD's demonstrated unwillingness to address known TRICARE problems** leads us to believe they will continue to resist program changes in the future. For instance, despite being given the authority to cover emerging technologies, TRICARE still covers only a fraction of Lab Developed Tests. This means military families are denied coverage for procedures such as noninvasive prenatal tests. DoD has also failed to address pediatric care problems identified in their own *Study on Health Care and Related Support for Children of Members of the Armed Forces*. We fear the cumulative impact of years of unresolved issues will continue to degrade the TRICARE benefit value over time.
- **Fee for service contracts prevent adoption of innovative reimbursement models.** As commercial health insurance and other government payers move toward a greater emphasis on preventative services and outcomes, TRICARE contracts are locked in to the fee for service model. DoD's most recent proposals to "simplify" TRICARE would only expand the fee for service model to the MTFs. This would continue to prevent military families from benefitting from innovations in medical care delivery.

Closing Remarks

We recognize many of the issues we have presented, viewed in isolation, may seem insignificant. However, we urge you to review this feedback with two facts in mind. First, when a military family seeks care in the MHS, their stressors only begin with the immediacy of the medical issue and stretch far beyond to the many extraordinary challenges of military life. Military families deserve a health care system that facilitates, rather than impedes, their access to care. Second, the cumulative impact of these obstacles, delays, and inconveniences magnifies the effect of each one and, in some cases, creates an insurmountable barrier to accessing necessary care.

After the past few years of pay raises below the ECI, BAH cuts, and multiple proposals to eliminate the Commissary benefit, military families are skeptical and likely to view MHS Reform as cuts in disguise. DoD's FY17 health care proposal – with its emphasis on fee increases and lack of detail on MHS improvements – magnifies these concerns. We stand ready to work with Congress and DoD, on behalf of military families, to achieve the stated objective of a Military Health System that works better for all beneficiaries.



February 23, 2016

The Honorable Lindsey Graham
Chairman
Subcommittee on Personnel
Armed Services Committee
United States Senate
Russell Senate Building, Room 228
Washington, DC 20515

The Honorable Kirsten Gillibrand
Ranking Member
Subcommittee on Personnel
Armed Services Committee
United States Senate
Russell Senate Building, Room 228
Washington, DC 20515

Chairman Graham, Ranking Member Gillibrand, and esteemed members of the Senate Armed Services Subcommittee on Personnel:

The Cleveland Clinic is honored and privileged to provide this testimony as you examine the current state of the Military Health System and recommend reforms to ensure our military men and women and their families are provided with high quality health care.

The Cleveland Clinic Health System is located in Northeast Ohio, with a main hospital, 13 community hospitals, 23 family health centers, 30 specialty clinics and more than a hundred community practice sites. Last year, we saw 1.9 million unique patients in 6.3 million individual encounters at our clinics in Ohio, Florida, Nevada, Toronto and Abu Dhabi. Our commitment to excellence in military health care stems back to our founding nearly 100 years ago by four military surgeons after their return from World War I, and the commitment to "act as a unit" through the strength of integrated group practice that is stronger than ever today.

In reviewing the January 2015 final report of the Military Compensation and Retirement Modernization Commission to this Committee, I am struck by the parallels between the challenges that were reported within the Military Health System (MHS) and those faced by the Cleveland Clinic Health System just a few years ago. The report cited lack of access and long wait times, a difficult to navigate appointment system, lack of access to the right doctor at the right time and place, narrow network constraints on access to care, quality issues attached to low volume, inefficiencies related to multiple command structures, and the challenges of managing dual objectives of force readiness and peacetime services on a system with limited resources.

The parallels between these issues in the Military Health System and modern civilian hospital systems like Cleveland Clinic cannot be overstated.

In 2007, the Cleveland Clinic was known for excellence in the practice of medicine, but we were not as well known for delivering excellent care. Our patient satisfaction numbers were below 55%. Our care organization was fragmented and compartmentalized, with little communication between providers, and even less between our patients and caregivers. Patients were faced with waiting days, sometimes

The Cleveland Clinic

9500 Euclid Avenue
Cleveland OH 44195



weeks, for appointments with specialists and primary care providers alike. We found ourselves so focused on managing administration of our care of the sick that we had nothing left to devote to keeping people well. Our costs were skyrocketing, and not the least the cost to provide healthcare to our then 43,000 employees. And for all our skill, our quality numbers were not in the “world class” category we were so proud to proclaim. Something big had to change, so we undertook to fundamentally transform the way we delivered healthcare.

The result has been the development of the Cleveland Clinic Integrated Care Model, which has these attributes at its core: It is personalized healthcare: patient-focused, integrated, continuous, and transcends time and physical location. The goal is to deliver the right care at the right time and right place, integrating across both primary and specialty care.

Our first move was to abandon the traditional department model for an institute model of care delivery that focused on patients, conditions and diseases, not siloed administration. In addition to streamlining and, in some cases, eliminating the administrative structure that was so pervasive in departments, we simplified and centralized the administration of our regional hospitals wherever it made sense. The result is a lighter-weight administration that works daily to strike a balance between standardizing and centralizing those functions that can and should be shared across all departments and regional hospitals, while preserving the individual needs and character of each care location and allowing it to thrive in a way that makes each individually successful. It’s a careful balance that takes hard work, wisdom and a commitment to continuous improvement, but the payoff for patients is more than worth the effort.

In an effort to build and maintain a high-reliability organization, we have undertaken to develop evidence-based Care Paths ensure that we can deliver reliable, high-quality care across the enterprise and the continuum of care, whether at one of our hospitals, outpatient offices, skilled nursing facilities or at home. Care Paths provide a standardized, template approach to ensure that each and every patient receives appropriate care, and that we can measure both our compliance with our own processes and treatment outcomes. This is not to remove the discretion and skill of the physician caregiver in the process. Rather, Care Paths allow us to understand, document, and measure the effectiveness of individual practice variances and propagate best practices that positively impact patient outcomes and deliver best value. To date, we have developed and implemented more than 130 Care Paths across the enterprise.

It is well-documented nationally that low volume procedures suffer from inconsistent cost and quality outcomes, and our experience at Cleveland Clinic was no exception. The quality variation between our main hospital and regional hospitals, and between our individual regional hospitals on surgeries such as joint replacement and cardiac catheterization, for example, was measured in quartiles, not deciles, and the costs could vary by as much as 20% between facilities. In order to optimize both our outcomes and our cost efficiency, we have adopted a model where patients needing certain specialty care are treated at the facilities that have consistently performed with the best outcomes and value – Centers of Excellence. For example, patients needing a total joint replacement of the knee or hip are directed to Cleveland Clinic regional hospitals on the west and east sides of Cleveland (Lutheran Hospital and Euclid Hospital, respectively) where we concentrated expertise in our surgical staff, our nursing staff and



physical therapy staff. The concentrated expertise and caregiver alignment afforded by this model has also allowed us to create pilot programs, such as our funded demonstration programs through the Center for Medicare and Medicaid Innovation (CMMI) that further transform care. Our Rapid Recovery Program is designed to reduce inpatient stays around primary total joint recovery, increase post-surgical discharge to home, reduce cost, and improve outcomes. Patients are identified at surgical consent as Rapid Recovery patients, and the care team engages both the patient and family caregivers in an activation and education program to prepare for post-surgical recovery. Patients learn about their surgery, their inpatient physical therapy regimen, their post-surgical care, and how to best prepare themselves for success. Their post-surgical physical therapy is more aggressive, starting the day of surgery, and they are prepared to discharge to home, with in-home nursing and physical therapy follow-up.

The outcomes are dramatic. Average length of stay has been reduced by more than a day for both hip and knee replacement. Discharge to home has increased from an average of 42% to more than 70%. Costs are 7% lower, even with in-home rehabilitation care. Most importantly, however, patient satisfaction is significantly higher and these patients report better average outcomes at 6 months. This sort of program is only possible because of the stability and dedication of the caregiver team and the engagement of all caregivers at these centers of excellence to improving outcomes and satisfaction.

Excellent care can only be delivered if the patient and the caregiver can connect. In 2013, Cleveland Clinic adopted a policy that no new patient should wait more than a week for an initial consult, and whenever possible should be seen the same day if a request is made. This standard is enforced without regard to acuity or specialty. The reason for this is simple – if a patient is ill, he or she just wants to get well. In 2015, Cleveland Clinic accommodated more than one million patient visits in same day appointments. Similar targets are set for post-discharge care for patients treated in our facilities. Most patients are seen in an outpatient or home-care setting within 48 hours of discharge.

The key to achieving these access standards is the development of a unified call center. Every Patient Service Representative (PSR) in the call center has access to each patient's complete appointment schedule, as well as access to physician openings across the entire enterprise of 13 hospitals, 23 family health and surgery centers, and 30 specialty care centers (plus more than 125 additional service sites across the enterprise). Further, these representatives have immediate connectivity to on-call and doctor's nurses to better triage and assess the specific needs of each patient – while still connected to the patient on the phone. Templates maintain consistency through the scheduling process, so each patient's encounter with scheduling is consistent and efficient. Call Center metrics focus on the patient experience: First contact resolution, speed of answer, and abandonment rate are all critical metrics.

Finally, we have recognized the importance of balancing the need to treat the sick with an ever-growing need to maintain individual and community wellness. This has caused us to make an enormous shift in our approach to delivering care. Our Care Transformation efforts now look holistically at the physical, behavioral, environmental and psycho-social determinants of health and recognize the need to address all of these to ensure that the healthy remain well and the sick get the care they need. We expanded our



care delivery model to include environments of care and different care providers, to better meet the complex needs of our evolving patient demographic. Where patients might have seen a doctor in an office or family health center, they may now see a nurse in their community center or a team of caregivers via a telehealth link. Our registered nurse care coordinators are embedded with the primary physician team and serve as the quarterback, educator and facilitator for our patients and patient family members. By identifying and targeting patient risk factors, we can control chronic diseases more effectively, increase wellness and reduce costs to both the organization and our payers.

At the core of all of this is the philosophy of Patients First. Our commitment to Patients First began with the establishment of our Office of Patient Experience, now under the direction of Adrienne Boissy, M.D. Patients First re-affirms our commitment to open, transparent communication, delivering care when and where it is most appropriate to the patient, and preserving patient involvement and dignity.

All aspects of the Cleveland Clinic Integrated Care Model are supported by an information technology infrastructure that enables meaningful communication and transfer of health information between providers, patients and family caregivers.

These efforts pay off. We have developed more than 130 evidence-based care paths in less than 24 months. Our efforts to institute care coordination with our employees with chronic diseases have reduced our own healthcare costs by more than \$23 million. Our commitment to Patients First increased our patient satisfaction scores from 55% to 92% in just four years. The transformation has involved every single employee of the Cleveland Clinic, each of whom is considered a caregiver and can articulate the role they play in ensuring that every Cleveland Clinic patient receives the best care we can deliver.

Our nation's military health system has a proud tradition of providing excellent care to the men and women who serve our nation, and their families. We owe it to them, as well as the myriad caregivers in the Military Health System (MHS) organization, to help enable the MHS to make the important transformation in its own systems to help it keep pace with a constantly evolving demographic. To this end, we recommend the adoption of several policy changes:

- Create partnerships between the MHS and civilian health care systems to refer patients outside the system when the right provider is not available or when wait times are unacceptably long, with TRICARE reimbursement rates that mirror Medicare rates to ensure access to a broad network of expert providers. This will reduce wait times for care, create access to the right providers at the right time, and to concentrate services at those facilities where the best expertise exists and be leveraged for optimal quality and cost. Create Centers of Excellence within and between the branches and in partnership with the civilian sector.
- Further consolidate the command structure military medical corps, including additional transparency and cooperation among the hospitals of the corps for each branch. While the health service of each branch has its unique strengths and challenges, the current system is siloed and redundant, from the Surgeons General down to the daily operations. This is not to say that the corps and commands should be abolished; each has its own important function and history that best reflects the needs of the patients it serves. Rather, identify the unique and vital



strengths of each branch and retain the value of those strengths, but eliminate redundancy in the administration across those functions that are common to all. We have seen ourselves that this sort of partnership, while not easy, can be done and done in a way that honors and preserves the best of what each organization has to offer.

- Re-focus the MHS and TRICARE to directly deliver only those services that bring the most value and focuses on what the MHS does best – care for the sick and wounded service member and maintain force readiness. Serving the health needs of military family members is vitally important to force readiness and resilience, but does not need to be directly delivered by the Military Health System. Helping TRICARE shift its role from provider-based to more purchased-based can free up vital resources for the direct services that are highest value.

In service to our nation, the Cleveland Clinic is prepared to advise, share best practices and work with the Military Health System to understand how and where models like our Integrated Care Model might ensure excellence and sustainability in care for our military personnel and their families.

Thank you for this opportunity to share with you our transformation story and to offer the Cleveland Clinic in service of your own mission.

TESTIMONY
OF THE
NATIONAL GUARD ASSOCIATION OF THE UNITED STATES
Senate Committee on Armed Services
Subcommittee on Personnel
Hearing on "Defense Health Care Reform"
February 23, 2106

Dear Chairman Graham and Ranking Member Gillibrand and other distinguished members of the Subcommittee:

On behalf of the more than 45,000 members of the National Guard Association of the United States and the nearly 500,000 soldiers and airmen of the National Guard, NGAUS strongly supports the recommendations of the Commission on Military Compensation and Retirement Modernization (MCRMC) on expanding health care insurance options.

Maintaining medical readiness, including dental readiness, allows the National Guard to be truly an operational reserve of the Army and Air Force. NGAUS supports any change in health care benefits that allow the National Guard to be ready to serve this nation at home and abroad.

The Commission recommends giving service members the option of selecting from the more than 250 health insurance plans available under the Federal Employees Health Benefits Program (FEHBP), calling the program TRICARE Choice. The Commission found that National Guard members are faced with difficult choices during mobilization and demobilization and that these transitions can be costly for Guard families and disruptive to health-care coverage. We believe that expanded choices for health insurance will be well-received by the National Guard for these reasons: access to care, number and location of providers, a less cumbersome referral and authorization process, limited provider networks and members' preference for greater choice and individuality.

Under this recommendation, DoD would sponsor and approve the levels of care of these commercial health insurance plans and service members and their families would not be subject to the same rates as other federal employees within FEHBP, but NGAUS remains concerned with the actual costs of these FEHBP plans. Right now, not every member of the Guard can afford health care, and along with maintaining military readiness, one of our top priorities is to see every member of the Guard and their families are able to afford health insurance. Although the research work of the Commission is broad, it's important we see the actual monthly costs of each program to a service member for the 250 plans that would be available under FEHBP. NGAUS would recommend the Committee bring in actuaries to do a cost-benefit analysis of each of the programs. Choice and the size of the provider networks should bring costs down, but these questions need to be answered before members and retirees of the Guard would feel secure in supporting the elimination of TRICARE as it now stands. We would hope if this recommendation

is enacted, that Congress would continue to monitor the fees, out-of-pocket costs and monthly deductibles of each program annually.

The Commission also recommends direct funding to apply to a Guard member's existing health insurance plan through a Basic Allowance for Health Care (BAHC) instead of requiring transition to a DoD-sponsored commercial program if this is their choice. NGAUS believe many members of the Guard, who have civilian jobs with civilian health insurance, would take advantage of this option as well.

Another issue of access to health care benefits important to NGAUS involves the men and women of the Guard who are military technicians. Our technician force is made up of the people who run our armories and wings on a daily basis. They do not have the same privileges under current law nor were changes to their access to health care insurance and addressed by the Commission.

There are other members of the National Guard who perform duties under Title 32 that also do not receive health care benefits that match their service and commitment. We hope that the Committee will look at all Guard statuses and erase this outdated caste system of benefits. These men and women should also be able to take advantage of a new modernized health care program and we ask that the Committee examine and act on options the bring equal benefits, accessibility and continuity of care to members of the Guard and their families under these statutes.

NGAUS looks forward to working with you to ensure proper, comprehensive and inclusive reform comes to our military health care system.

Thank you again, Chairman Graham and Ranking Member Gillibrand, for your interest and commitment to the members of the National Guard.



NGAUS FY2017 Fact Sheet

Reforming TRICARE

Recommendation

The National Guard Association of the United States urges the Congress to support and authorize expanded military health care options allowing members of the Reserve Component to choose from a selection of commercial health insurance plans offered through "TRICARE Choice."

Background

The Commission on Military Compensation and Retirement Modernization

recommends that changes and alternatives to TRICARE are in order citing problems with access to care, number and location of providers, cumbersome referral and authorization process, limited provider networks and members preference for a greater choice.



The members of the National Guard have always faced difficult choices during mobilization and demobilization and know how costly and confusing these transitions can be for them and their families moving on and off TRICARE. Disruptions in health care coverage, services, and providers have occurred. These problems are even more magnified when a member of the Guard is not supporting a contingency operation. For these reasons alone, it is worth considering a different approach to health care for the reserve component.



The Commission recommends giving service members the option of selecting from the more than 250 health insurance plans available under the Federal Employees Health Benefits Program (FEHBP). This program would be called TRICARE Choice and administered by OPM. The DoD would sponsor and approve the levels of care of these commercial health insurance plans. The thought is that more physicians are available in FEHBP networks and that it is more likely RC families' civilian job health insurance physicians are one in the same. Service members and their families would not be subject to the same rates as other federal employees within FEHBP. ***It will be important in the future, that the rates and fees under these programs are monitored by Congress.***

In another positive step for the National Guard, DoD could instead fund part of the RC member's existing health insurance plan instead of requiring transition to a DoD-sponsored commercial programs. For example, RC members who are mobilized would receive a new Basic Allowance for Health Care (BAHC) to apply toward a DoD plan or to cover the employees share of their existing health care plans.

Only TRICARE for Life, TRICARE Dental Program and Retiree Dental Program would remain in their current form. TRICARE Prime, Standard, Extra, Reserve Select, Retired Reserve, Young Adult would be replaced with TRICARE Choice. RC members cost shares in TRICARE Choice, should they choose this plan, would be based on their category of service, and under TRICARE Choice, National Guard members now on TRICARE Reserve Select would have premium cost shares reduced to 25% to improve RC medical and dental readiness. They would continue to have access to the TRICARE Dental Program and access to vision coverage now not available.

Importance

The National Guard would receive a better health care benefit by allowing them to choose from a selection of commercial insurance plans offered through a DoD health benefit program.



Statement
Of
The National Association of Chain Drug Stores
For
United States Senate
Committee on Armed Services
Subcommittee on Personnel
Hearing on:
Defense Health Care Reform
February 23, 2016
2:30 p.m.
SD-G50 Dirksen Senate Office Building

National Association of Chain Drug Stores (NACDS)
1776 Wilson Blvd., Suite 200
Arlington, VA 22209

NACDS Statement for the Record: U.S. Senate Armed Services Subcommittee on Personnel Hearing on
Defense Health Care Reform
February 23, 2016
Page 2 of 7

Introduction

The National Association of Chain Drug Stores (NACDS) thanks the Subcommittee for the opportunity to submit a statement for the hearing on the “Defense Health Care Reform.” NACDS and the chain pharmacy industry are committed to partnering with Congress, the Department of Defense (DoD), and other healthcare providers to improve the quality and affordability of healthcare services for our nation’s military heroes, retirees, and their families.

NACDS represents traditional drug stores and supermarkets and mass merchants with pharmacies. Chains operate more than 40,000 pharmacies, and NACDS’ chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ more than 3.2 million individuals, including 179,000 pharmacists. They fill over 2.9 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 850 supplier partners and over 60 international members representing 22 countries. For more information, visit www.NACDS.org.

As the face of neighborhood healthcare, community pharmacies and pharmacists provide access to prescription medications and over-the-counter products, as well as cost-effective health services such as immunizations and disease screenings. Through personal interactions with patients, face-to-face consultations and convenient access to preventive care services, local pharmacists are helping to shape the healthcare delivery system of tomorrow—in partnership with doctors, nurses, and others. As policies to control spending in the TRICARE program are considered, NACDS urges Congress to protect patient health and preserve access to local pharmacies.

Preserving Patient Access and Choice in the TRICARE Program

Recent changes to reduce TRICARE costs through copayment increases and requiring beneficiaries to obtain certain prescriptions at a military treatment facility (MTF) or through mail have negatively impacted the program through reduced beneficiary access and only served to shift costs to other federal programs. While these significant changes may appear to save money in the short run, they actually are more costly over the long term. Failure to take medications as prescribed costs the U.S. health system \$290 billion annually, or 13% of total health expenditures. It has been established that higher copayments cause some chronically ill beneficiaries to stop taking their medications, resulting in more doctor visits and hospitalizations. In the TRICARE program, the costs associated with increased medical utilization are generally shifted to the Medicare program. In 2012, the Congressional Budget Office (CBO) issued a report which revised its methodology for scoring proposals related to prescription drug use and found that for each one percent increase in the number of prescriptions filled by beneficiaries there is a corresponding decrease in overall medical spending. In reviewing the original Senate version of the FY2016 NDAA, which proposed increases in prescription copays for TRICARE beneficiaries, the CBO applied this methodology and stated:

Thus, while the higher copayments may deter some beneficiaries from filling prescriptions they no longer need or use, those higher copayments also could cause some chronically ill beneficiaries to stop taking their medications, resulting in more doctor visits and hospitalizations. As a result, CBO estimates that the \$4.9 billion in direct pharmacy savings would be offset by a \$1.1 billion increase in other federal spending for medical services (mostly from Medicare).

As policies to control spending in the DoD are again considered, NACDS urges Congress to implement changes that reduce TRICARE costs without jeopardizing patient health

and access to services. One way in which we believe this can be accomplished is through a pilot program testing acquisition cost parity for prescription drugs dispensed through retail pharmacies. The DoD currently purchases medications that are dispensed at mail order and MTFs at a cost much lower than in the retail setting. Under the pilot, the DoD will purchase prescription drugs that are dispensed in the retail setting to retired TRICARE beneficiaries who are not Medicare eligible at the lowest price available to the DoD. This includes pricing available through the Federal Supply Schedule, Federal Ceiling Price, and discounts available through the DoD's Prime Vendor contracting process to include supplemental discounts offered by pharmaceutical manufacturers in the form of temporary price reductions (TPR), blanket purchase agreements (BPA), or distribution and pricing agreements (DAPA).

Savings to the government will be obtained through reduced acquisition costs for prescription drugs by allowing the DoD to purchase prescription drugs dispensed in the retail setting at the much lower mail and MTF rate and therefore creating parity in the net cost of prescription drugs at all filling venues. For example, the pilot will eliminate the 32 percent average cost difference for brand name maintenance medication prescriptions filled in mail and MTFs versus the cost to dispense the same medications in the retail setting. The pilot program will also lower the administrative cost of dispensing all prescriptions. It is believed that the current administrative fees for prescriptions filled through mail order may be as much as 40 percent higher than the retail setting. The pilot will reduce the costs associated with administrative fees by allowing beneficiaries to obtain their prescriptions at more cost-effective retail pharmacies.

Not only will acquisition cost parity for retail prescription achieve cost savings but it will also preserve freedom of choice for TRICARE beneficiaries and provide a uniform and consistent pharmacy benefit with less confusion on where to fill prescriptions. This will ultimately lead to improved beneficiary health through a local relationship with their hometown pharmacist.

NACDS Statement for the Record: U.S. Senate Armed Services Subcommittee on Personnel Hearing on
Defense Health Care Reform
February 23, 2016
Page 5 of 7

NACDS is opposed to the proposal in the President's budget to make additional changes to pharmacy copayments that would further drive TRICARE beneficiaries out of their local pharmacies and to mail order. There are already strong incentives in place to encourage beneficiaries to use mail order, nevertheless, the President's budget includes additional changes.

NACDS support sensible cost savings initiatives. Thus, we urge Congress to support TRICARE beneficiaries in obtaining their prescription medications at their local pharmacies. Doing so would decrease overall program costs while also preserving beneficiaries' health and wellness.

Medication Therapy Management Improves Health Outcomes and Reduces Spending

Last year, the Military Compensation and Retirement Modernization Commission (Commission) issued its final report and recommendation for modernizing and improving the military healthcare system. The Commission heard from beneficiaries about the importance of healthcare provider choice and access and strongly recommended patient choice, flexibility, access to care, and utilizing the latest healthcare innovations, such as medication therapy management (MTM). Moreover, the Commission specifically recommended that the TRICARE pharmacy benefit should integrate pharmaceutical treatment with healthcare and implement a robust MTM program.

MTM is a distinct service or group of services that optimize therapeutic outcomes of medications for individuals based on their unique needs. MTM services increase medication adherence, enhance communication and collaboration among providers and patients, optimize medication use, and reduce overall healthcare costs.

Policymakers have recognized the vital role that local pharmacists can play in improving medication adherence. The role of appropriate medication use in lowering healthcare costs has been acknowledged by the CBO when it revised its methodology for scoring proposals related to Medicare Part D, finding that for each one percent increase in the

NACDS Statement for the Record: U.S. Senate Armed Services Subcommittee on Personnel Hearing on
Defense Health Care Reform
February 23, 2016
Page 6 of 7

number of prescriptions filled by beneficiaries there is a decrease in overall Medicare spending. Similarly, a study published last year in *Health Affairs* examined the impact of changes in prescription drug use on medical costs in the Medicaid program. The study found that a one percent increase in overall prescription drug use was associated with decreases in total nondrug Medicaid costs by a percentage comparable to that found by the CBO.

Congress has also recognized the importance of pharmacist-provided services such as MTM by including it as a required offering in the Medicare Part D program. The experiences of Part D beneficiaries, as well as public and private studies, have confirmed the effectiveness of pharmacist-provided MTM. A 2013 CMS report found that Part D MTM programs consistently and substantially improved medication adherence and quality of prescribing for evidence-based medications for beneficiaries with congestive heart failure, COPD, and diabetes. The study also found significant reductions in hospital costs, particularly when a comprehensive medication review (CMR) was utilized. This included savings of nearly \$400 to \$525 in lower overall hospitalization costs for beneficiaries with diabetes and congestive heart failure. The report also found that MTM can lead to reduced costs in the Part D program as well, showing that the best performing plan reduced Part D costs for diabetes patients by an average of \$45 per patient.

A study of published research on medication adherence conducted by Avalere in 2013 concluded that the evidence largely shows that patients who are adherent to their medications have more favorable health outcomes such as reduced mortality and use fewer healthcare services (especially hospital readmissions and ER visits). Such patients are thus cheaper to treat overall, relative to non-adherent patients. The study found that there was even wider range of cost offsets for patients demonstrating adherence to medications across particular chronic conditions.

How and where MTM services are provided also impacts its effectiveness. A study published in the January 2012 edition of *Health Affairs* identified the key role of retail pharmacies in providing MTM services. The study found that a pharmacy-based

NACDS Statement for the Record: U.S. Senate Armed Services Subcommittee on Personnel Hearing on
Defense Health Care Reform
February 23, 2016
Page 7 of 7

intervention program increased adherence for patients with diabetes and that the benefits were greater for those who received counseling in a retail, face-to-face setting as opposed to a phone call from a mail-order pharmacist. The study suggested that interventions such as in-person, face-to-face interaction between the retail pharmacist and the patient contributed to improved adherence with a return on investment of 3 to 1.

Americans rely heavily on their local retail pharmacies for a wide range of cost-saving services, including acute care and preventive services, such as MTM services. Beneficiaries that know and trust their local retail pharmacists for such services are being forced to obtain medications from mail order facilities in remote locations with no opportunity for in-person consultation. There is no substitute for the pharmacist-patient face-to-face relationship. Community pharmacy services help to improve patient health and lower overall healthcare costs. Maintaining patient choice of how to obtain prescription medications is essential. For these reasons, NACDS urges adoption of the Commission's recommendation to implement a robust TRICARE MTM program.

Conclusion

Thank you for the opportunity to share our views. We look forward to working with you on policies that control costs and preserve access to local pharmacies.



Statement of
The Fleet Reserve Association
on
Defense Health Care Reform
Submitted to:
Senate Armed Services Committee
Personnel Subcommittee

By
John R. Davis
Director, Legislative Programs

February 23, 2016

The FRA

The Fleet Reserve Association (FRA) celebrated 91 years of service last November 11, and is the oldest and largest enlisted organization serving active duty, Reserves, retired and veterans of the Navy, Marine Corps, and Coast Guard. It is Congressionally Chartered, recognized by the Department of Veterans Affairs (VA) as an accrediting Veteran Service Organization (VSO) for claim representation and entrusted to serve all veterans who seek its help. In 2007, FRA was selected for full membership on the National Veterans' Day Committee.

FRA was established in 1924 and its name is derived from the Navy's program for personnel transferring to the Fleet Reserve or Fleet Marine Corps Reserve after 20 or more years of active duty, but less than 30 years for retirement purposes. During the required period of service in the Fleet Reserve, assigned personnel earn retainer pay and are subject to recall by the Navy or Marine Corps.

FRA's mission is to act as the premier "watch dog" group in maintaining and improving the quality of life for Sea Service personnel and their families. FRA is a leading advocate on Capitol Hill for enlisted active duty, reserve, retired and veterans of the Sea Services. FRA sponsors a National Americanism Essay Program and the FRA Education Foundation oversees the FRA's scholarship program that presents awards to deserving students each year, that on average exceed \$100,000.

The Association is also a founding member of The Military Coalition (TMC), a 31-member consortium of military and veteran's organizations. FRA hosts most TMC meetings and members of its staff serve in a number of TMC leadership roles.

For more than nine decades, dedication to its members has resulted in legislation enhancing quality of life programs for Sea Services personnel, other members of the uniformed services plus their families and survivors, while protecting their rights and privileges. CHAMPUS, (now TRICARE Standard) was an initiative of FRA, as was the Uniformed Services Survivor Benefit Plan (USSBP). FRA led the way in reforming the REDUX Retirement Plan, obtaining targeted pay increases for mid-level enlisted personnel, and sea pay for junior enlisted sailors. FRA also played a leading role in advocating recently enacted predatory lending protections and absentee voting reform for service members and their dependents. More recently the Association played a leading role in abolishing legislation requiring current retirees to get a one-percent reduction in their annual cost-of-living-adjustment (COLA) until they reach age 62.

FRA's motto is: "Loyalty, Protection, and Service."

Certification of Non-Receipt Of Federal Funds

Pursuant to the requirements of House Rule XI, the Fleet Reserve Association has not received any federal grant or contract during the current fiscal year or either of the two previous fiscal years.

Defense out of Sequestration

Before commenting on military health care reform, FRA wants to note with growing concern the long-term impact of sequestration. Budget cuts mandated by the Budget Control Act of 2011 pose a threat to national security and will substantially impact member pay and benefits. These automatic cuts, known as Sequestration, require that 50 percent come from Defense, even though Defense only makes up 17 percent of the federal budget. FRA appreciates last year's budget deal eliminates a sequestration mandated \$38 billion cut in the FY 2016 Defense budget, and smaller cuts for FY 2017. However, without additional changes to the law, more sequestration cuts are scheduled for FY 2018 thru 2021 remain continuing to place national security at risk.

Former Secretary of Defense (SecDef) Chuck Hagel warned in 2011 that future sequestration budget cuts will create a "hollow force." The Services have already canceled deployment of ships, slashed flying hours, renegotiated critical procurement contracts, temporarily furloughed civilian employees, and are in the process of reducing force structure, giving America the smallest military force since before World War II. If sequestration is not ended, additional force reductions will likely go deeper and training and modernization levels will be further impacted. Nearly 86 percent of retirees that participated in FRA's online survey (January/February 2016) are "Very concerned" (the highest rating) about continuing sequestration cuts.

TRICARE Fee Increases

For several years now the Administration has included in their annual budget request fee increases for many TRICARE beneficiaries, and this year is no different. The FY 2017 budget request includes enrollment fee increases for TRICARE Prime far beyond the current mandated fee increases. It includes a new "participation" fee for TRICARE Standard, and a new fee for new enrollees for TRICARE-for-Life. The plan also includes higher pharmacy co-pays and higher deductibles. FRA opposes these proposed fee increases because the Association believes that a military retiree's health care premium, is at least in part, paid for with 20 or more years of arduous military service. In FRA's online survey retirees were asked, *"Do you believe that retired service members have, at least in part, earned their TRICARE services through 20-plus years of military service?"* More than 99 percent of retirees said "Yes." Many of these beneficiaries targeted by fee increases will tell you that they were told that they would have free health care for life if they endured low pay and arduous service. In FRA's online survey

(January/February 2016) retirees were asked *"When you joined the military, were you led to believe that you would have free health care for life if you stayed in long enough to retire?"* Exactly 96 percent answered "Yes."

Nearly 94 percent of retirees see TRICARE benefits as very important in FRA's most recent online survey. FRA advocates that the Defense Department (DoD) must sufficiently investigate and implement other options to make TRICARE more cost-efficient as alternatives to shifting costs to TRICARE beneficiaries, and the Association opposes any indexing of future TRICARE Fee increases beyond CPI indexed to COLA increases. In FRA's online survey of retirees (January/February 2016) finds that more than 81 percent see the cost of TRICARE premiums as "Very important."

TRICARE Reform

The House and Senate Armed Services Committees want to reform the TRICARE program and plan to craft legislation this year to achieve this objective. FRA supports the Military Coalition (TMC) testimony that was provided to the Subcommittee. It seems that the starting point will be the health care recommendations from the Military Compensation and Retirement Modernization Commission (MCRMC) that suggests that TRICARE be replaced with a plan similar to the Federal Employee Health Benefit Program (FEHBP). Beneficiaries would be switched to a plan similar to the FEHBP, except that Military Treatment Facilities (MTF) would be included in the network. Like the FEHBP, beneficiaries could choose from a selection of commercial insurance plans. The plan would be administered by the Office of Personnel Management (OPM) rather than the DoD. Beneficiaries would be required to pay 20 percent of all health care costs. Beneficiary family members would not be covered under the plan and would be provided a Basic Allowance for Health Care (BAHC) to cover the cost of premiums and deductibles for an average health care plan. Reserve Component (RC) members who are mobilized would also receive a BAHC in lieu of TRICARE coverage.

Although there are similarities between the BAHC and the Base Allowance for Housing (BAH), the big difference between the two is that housing costs are predictable but health care costs are not. FRA will oppose this provision. The MCRMC proposal recommends that "Non-Medicare eligible retirees should continue to have full access to the military health benefit program at cost contributions that gradually increase over many years..." These retirees under age 65 would eventually be required to pay 20 percent of all health care costs, and premiums would be increased every year to ensure that beneficiaries keep paying 20 percent. The FY 2013 National Defense Authorization Act (H.R. 4310 – P.L. 112-239) established the MCRMC. FRA notes that no enlisted personnel were appointed to serve on the Commission. More than 75 percent of the current active force is enlisted and therefore should have been represented on this Commission.

FRA believes that a military retiree's health care premium, is at least in part, paid for with 20 or more years of arduous military service. FRA advocates that military beneficiaries incur distinctive and extraordinary physical and mental stresses that are completely different to the service conditions of federal civilian employees, and their health benefits should be significantly better than civilian programs. The military health care system is also called upon to provide combat casualty care, and in recent years has proven to be an efficient system that saves countless number of service member's lives, who would have died in earlier conflicts. So the Association would question the use of the FEHPB as a good model for reforming the Military Health System (MHS). The Association welcomes the review and reform, but is not convinced that TRICARE cannot be fixed. In FRA's current online survey (January/February 2016) retirees were asked *"It has been asserted in Congress that TRICARE is irrevocably broken. Would you support replacing TRICARE with a program that costs more but offers a selection of benefits?"* Nearly 90 percent (89.94) responded "No."

No one should assume that FRA is opposed to changing and improving MHS. The Association has supported proposals to create a unified medical command that would have substantial cost savings for the system. FRA would also point-out the failure of DoD and VA to create a joint interoperable electronic health record as a major disappointment. FRA welcomes MCRMC recommendation 8 that attempts to improve collaboration between DoD and the Department of Veterans Affairs (VA). FRA supports a joint electronic health record that will help ensure a seamless transition from DoD to VA for wounded warriors, and establishment and operation of the Wounded Warriors Resource Center as a single point of contact for service members, their family members, and primary care givers. The Association is concerned about shifting of departmental oversight from the Senior Oversight Committee (SOC) comprised of the DoD and VA secretaries per provisions of the FY 2009 National Defense Authorization Act (NDAA), to the lower echelon Joint Executive Council (JEC). This change is perceived by many as diminishing the importance of improving significant challenges faced by service members – particularly wounded warriors and their families – in transitioning from DoD to the VA. The recommendation to provide additional authority to the JEC is a step in the right direction.

Further FRA members have expressed frustration with TRICARE Prime referrals. The MCRMC report notes that TRICARE Prime beneficiaries in some locations that have half of the referrals for purchased care network waited longer than the 28-day standard for purchased care network. Even in locations with the highest access to care, 16 percent of referrals still do not get appointments within the 28-day standard. Perhaps a pilot program in a limited geographic location, not currently served by TRICARE Prime, could demonstrate the efficiency of the plan.

The Association supports MCRMC recommendation 7 that seeks to improve support for service members with special dependents. These improvements to the Extended Care Health Option (ECHO) include expanded respite care hours, and consumer directed care. FRA wants to make sure that U.S. Coast Guard personnel are also covered by this program. FRA represents the Sea Services and wants to ensure that the Coast Guard benefits have parity with DoD benefits.

FRA's membership appreciates the following Sense of Congress (SOC) in the FY 2013 National Defense Authorization Act (NDAA): (1) DoD and the Nation have a committed health benefit obligation to retired military personnel that exceeds the obligation of corporate employers to civilian employees; (2) DoD has many additional options to constrain the growth of health care spending in ways that do not disadvantage beneficiaries, and (3) DoD should first pursue all options rather than seeking large fee increases or marginalize the benefit for beneficiaries.

The whole purpose of a unique military health care benefit is to offset the extraordinary demands and sacrifices expected in a military career. FRA advocates that to sustain a first-class, career military force requires a strong bond of mutual commitment between the service member and his/her employer.

CONCLUSION

FRA is grateful for the opportunity to present these recommendations to this distinguished Subcommittee on the important issue of military health care reform.



201 North Washington Street
Alexandria, Virginia 22314
(703) 838-8143

STATEMENT OF
THE MILITARY COALITION (TMC)
Submitted to the
SENATE ARMED SERVICES
SUBCOMMITTEE ON PERSONNEL

concerning
Military Health Care Reform

February 23, 2016

CHAIRMAN GRAHAM, RANKING MEMBER GILLIBRAND, AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE. On behalf of The Military Coalition (TMC), a consortium of nationally prominent uniformed services and veterans' organizations, we are grateful to the committee for this opportunity to express our views concerning military healthcare reform. This statement for the record provides the collective views of the following military and veterans' organizations, which represent approximately 5 million current and former members of the seven uniformed services, plus their families and survivors:

Air Force Sergeants Association
 Air Force Women Officers Associated
 AMVETS
 Army Aviation Association of America
 Association of Military Surgeons of the United States
 Association of the United States Army
 Association of the United States Navy
 Chief Warrant and Warrant Officer Association, U.S. Coast Guard
 Commissioned Officers Association of the U.S. Public Health Service, Inc.
 Fleet Reserve Association
 Gold Star Wives, Inc.
 Iraq and Afghanistan Veterans of America
 Jewish War Veterans of the United States of America
 Marine Corps Reserve Association
 Military Chaplains Association of the United States of America
 Military Officers Association of America
 Military Order of the Purple Heart
 National Association for Uniformed Services
 National Military Family Association
 Naval Enlisted Reserve Association
 Non Commissioned Officers Association
 The Retired Enlisted Association
 United States Army Warrant Officers Association
 United States Coast Guard Chief Petty Officers Association
 Veterans of Foreign Wars

The Military Coalition, Inc. does not receive any grants or contracts from the federal government.

We are very appreciative that you and the Subcommittee are seeking to ensure military health programs sustain medical readiness; deliver timely, top-quality care; and sustain benefit and cost-share levels for active duty, Guard and Reserve, and retired members and their families and survivors that are consistent with their extended and arduous service and sacrifice in uniform.

The Military Coalition understands the current and future national security situation requires us to maintain a balance of investment in equipment, training, operational capabilities, as well as the personnel requirements which have been the cornerstone of the success of our all-volunteer force. There are finite resources for these competing demands and we strongly agree the Military Healthcare System (MHS) needs to evolve beyond what it is today, into a modern, high-performing integrated system, delivering quality, accessible care safely and effectively to its beneficiaries – while simultaneously meeting international health crises and national disasters, and honing its readiness capabilities. No other health care entity in the country is charged with these dual, yet mutually interdependent, mandates.

In our collective pursuit of needed military healthcare reforms, our guiding principle should be the first principle of medical ethics – first, do no harm.

We all share the common goals of sustaining medical readiness, delivering top-quality care, and avoiding damage to the career retention value of the military healthcare benefit.

In that context, we offer this statement for the record, which provides you with our assessment on which elements of current military healthcare programs that are working and which ones are not and our principles for health care reform. This will be followed by our views on the FY2017 DOD budget request.

What Is Working in the Current System

Combat Casualty Care. Battlefield care, evacuation systems, and treatment and rehabilitation for multiple and traumatic injuries have significantly reduced combat deaths and improved the quality of life for thousands of combat veterans. In many cases, members who would have died in previous conflicts have even been able to return to active service.

Quality of Care. Beneficiaries of all ages are satisfied with the quality of care they receive from both military and civilian providers, once they are able to access the care. MOAA's survey of more than 17,000 beneficiaries generated "mostly satisfied" or "very satisfied" responses from 85% of TRICARE Prime enrollees, 88% of TRICARE Standard beneficiaries, and 95% of TRICARE For Life beneficiaries.

TRICARE For Life (TFL). TFL worked as intended, and perhaps even better than anticipated, from the start. ***We strongly believe this was due in large measure to the unprecedented outreach by the Defense Department at the time to include beneficiary organizations in the planning and implementation process. A joint TFL Working Group comprised of TRICARE***

officials and Military Coalition representatives met virtually weekly for many months to identify and resolve technical and policy issues, and develop processes and communication strategies to ensure smooth operational implementation. A key aspect was the collective effort to educate beneficiaries and providers alike on exactly how the new program would work, including real-time integration with Medicare systems, ease of enrollment and elimination of paperwork for beneficiaries, and ease of claims processing/rapidity of payment for providers. A recent MOAA survey of more than 10,000 TFL beneficiaries showed dissatisfaction rates in the low single digits across the board on ability to choose providers, access to care, and beneficiary costs. TFL is truly fulfilling the longstanding promise of lifetime military healthcare in return for a career of service.

Pharmacy Programs. Pharmacy programs are successful in meeting beneficiary needs. Past surveys of the home delivery system have indicated 95% satisfaction with that program. The home delivery policy was an excellent example of the beneficiary community partnering with DoD with the goal to lower health care costs and sustain the quality of the benefit. However, recent copay increases, for retail pharmacies in particular, are a source of dissatisfaction.

TRICARE Standard (mostly). For under-65 beneficiaries frustrated with various aspects of TRICARE Prime, the Standard option provides significantly higher satisfaction – and perhaps more importantly, much lower dissatisfaction – on issues of beneficiary control. For example, Standard beneficiary participants in MOAA's survey indicated 83% satisfaction and 7% dissatisfaction (with 10% neutral) with their ability to choose providers, compared to 63% and 17%, respectively among Prime enrollees (20% neutral). Standard and Prime beneficiaries were roughly equally satisfied on ease and timeliness of appointment-making, but Standard dissatisfaction rankings on these scores (6-10%) were roughly half those reported for Prime (10-18%).

The TRICARE Overseas Program. Prior to 2009, separate contracts and government employees provided support for overseas purchased-care network relationships, medical oversight and management, enrollment, claims processing, service center support, the TRICARE Global Remote Overseas program, and TRICARE Prime in Puerto Rico. In 2009, a contract was awarded to consolidate these functions through the delivery of integrated, comprehensive health care support services through the TRICARE Overseas Program (TOP), recognizing its uniqueness in support of the deployed force, readiness requirements, and families stationed overseas. A new TOP contract introducing additional medical management and beneficiary support services begins in 2016 and provides for further integration of direct care and purchased care delivery with appropriate medical oversight. Original demonstration projects such as in the Philippines have evolved into a success and should now be made permanent.

Problem Areas

TRICARE Prime Appointing. Prime enrollees' feedback has been generally consistent that "the quality of my care has been excellent....once I can get in." Appointing systems vary by location, but it has been well documented that too many Prime beneficiaries are being told such things as, "we have no more appointments this month; call back again [on some future date]" or "it will be [months] before we can get you in." Too often, appointing offices are either ignorant of or ignore TRICARE Prime's timely access standards in failing to offer more timely appointments with civilian providers as an alternative to an appointment in the military facility.

TRICARE Prime Referrals. The bureaucratic process of obtaining a specialty consult in a timely and efficient manner remains a source of significant beneficiary dissatisfaction. The problem is mainly with referrals from military treatment facilities for outside care. Beneficiaries complain about how long it takes to get a referral. They may have to talk with several people for this to happen, and the beneficiary often has to be the lead advocate to complete the referral process. In other cases, beneficiaries receive a referral to a provider that is significantly inconvenient for them in terms of distance or timeliness, and the report of the specialty visit often does not make its way back into the beneficiary's medical record. The new electronic health record is touted as addressing these problems, but the record of implementing such programs does not inspire confidence.

Guard/Reserve TRICARE Coverage. The Coalition believes there are significant inconsistencies and inequities in the level and continuity of coverage provided to Guard and Reserve (G/R) beneficiaries at various points in their careers, mostly because of the piecemeal addition of various programs, and the availability of funding at the time each element was enacted. The Subcommittee's recent authorization of transition coverage for separating TRICARE Reserve Select enrollees was one step in the right direction. But continuing problems include:

- (a) Delay in activation of TRICARE coverage when members are activated under various types of orders, or interruption when activation orders are changed to another category;
- (b) Disruption of family health coverage continuity for G/R members who would prefer to keep private employer coverage for their families upon activation rather than switching the families to TRICARE;
- (c) Ineligibility of TRICARE Reserve Select families for TRICARE Prime, even when that option would be both beneficial for the government and helpful to the beneficiary;
- (d) Denial of equal TRICARE eligibility to all members drawing retired pay, in that G/R members who begin receiving retired pay before age 60 as a result of qualifying deployments are the only retired-pay recipients deemed ineligible for full TRICARE Standard/Prime; and
- (e) The unsubsidized nature of TRICARE Retired Reserve coverage, which means annual individual/family enrollment fees for G/R members rise abruptly from \$575/\$2,530 to \$4,665/\$11,489 upon entering "gray area" status.

Military Treatment Facility Patient Load. This issue is at the core of the TRICARE Prime appointment problems and a significant factor in DoD healthcare costs. ***The fact is that military providers see significantly fewer patients per day than civilian providers do.*** There are some budget, staffing and other issues that contribute to that situation, but increasing patient loads to be more comparable with civilian providers' would improve military providers' medical skills and improve beneficiary access to care while also reducing DoD costs. Constraining in-house caseloads drives more beneficiaries to private-sector care, which drives up DoD costs...for which DoD seems to be blaming beneficiaries and trying to raise their fees. Simply put, ***beneficiaries shouldn't be blamed and have their cost-shares raised because military facilities are not efficient providers of care.***

Pediatric Coverage. Too often, TRICARE reimbursement policy is based on Medicare policy, which does not make sense for children. In many cases, the payment codes do not reflect the value of the "covered services." In such instances, TRICARE tells providers and families certain care is covered, then refuses to pay after the care is provided. Examples of this circular policy in which treatment is "covered" but reimbursement is not included in the amount paid to the provider include melody heart valve, conscious sedation (e.g., for wound care or MRI for young children or children with special needs), and emerging technology. Further, TRICARE has an "inpatient only" list, designating procedures that must be performed inpatient. Again, it often adopts the lists straight from Medicare. The list includes many procedures commonly performed on an outpatient basis for children. This places physicians and hospitals in the untenable position of performing the procedures outpatient in the best interests of the child (and receive NO payment for services rendered) or satisfying TRICARE's requirement to hospitalize the child, with attendant family disruption, burdens, and a less than optimal care setting. Neither option reflects good health care policy for military families. Ironically, the inpatient care is typically triple the cost of the outpatient procedure. ***TRICARE should not ask pediatric providers to absorb the cost of medically appropriate care for children or to choose inappropriate, elder-based care options when the best pediatric practice calls for something different.*** TRICARE has acknowledged these problems for more than four years, but has provided no relief.

Special-Needs Families. The Military Compensation and Retirement Modernization Commission (MCRMC) noted military programs for family members with special needs often fall short, especially because frequently relocating military families are repeatedly pushed to the back of waiting lists for crucial state Medicaid programs. We agree with the MCRMC recommendation to assist these families by aligning services under the Extended Care Health Option (ECHO) with those of state Medicaid waiver programs. Guard and Reserve families are particularly vulnerable during transitional periods and should have an extension of support. Further, it is imperative for the benefit to include members of all seven of the uniformed services.

Medical Record Systems. The failure to create a joint interoperable electronic health record useable by both DoD and the VA is a well-documented problem, with no viable plan to meet congressional requirements on the horizon. In effect, the Defense Department effectively has

abandoned the effort and is pursuing its own new system. As long as this is the case, DoD will continue to disadvantage transitioning servicemembers, and will continue to have great difficulties providing continuity of care and coordinating care provided in military facilities with care obtained from civilian providers.

Health Care Budgeting/Oversight. The Coalition continues to believe the current structure built around three different service healthcare programs and multiple different contract providers, with no single point of budget control and program oversight, effectively promotes inefficiency. The MCRMC proposal to create a Joint Readiness Command with oversight of medical readiness would add another administrative layer without addressing the need for a single budget/program oversight. We agree with past proposals to create a Unified Medical Command to address this fundamental shortcoming.

TRICARE Young Adult (TYA) Costs. Unlike commercial insurers that spread the cost of young adult coverage across all beneficiaries, TYA is the only coverage program for young adults that requires the individual (or often the parents) to bear the full cost of his or her incremental coverage. The recent 2016 TYA premium increase from \$2,172/\$2,496 (TRICARE Standard/Prime) per person to \$2,736/\$3,672 – a 26%/47% rise -- is particularly onerous for families with more than one eligible child in this category. The TRICARE practice stands in stark contrast to the invisible differential experienced by parents with private insurance, where the cost of the added young adults' coverage is shared across all beneficiary families, so that all pay slightly more rather than placing the entire burden on the relatively small number of individual young adults.

Case Management/Wellness. DoD has some projects underway on these topics, but much more can and should be done. Congress excluded Medicare-eligibles from requirements for selected wellness pilot projects (e.g., smoking cessation) because of mandatory spending considerations, but there is no constraint on DoD including them by policy to reduce long-term costs. There are any number of high-cost/chronic healthcare consumers among Medicare-eligibles, TRICARE Reserve Select enrollees, TRICARE Standard users or others not eligible for TRICARE Prime who likely would be happy to be included in coordinated-care or other case management programs, either inside or outside military facilities. Outreach efforts to provide more structured and coordinated care to non-Prime eligibles with special needs, or other high-use or chronic medical conditions could provide a better quality of life and less appointment/referral hassles for the patient/family while simultaneously reducing short- and long-term government costs.

DoD/VA Seamless Transition. The problems in this area are well-documented. After more than a decade in the spotlight, the issues that are left are the more intransigent of the bureaucratic problems. While no one questions the collective desire to see them resolved, the question is whether there is a continued leadership will and priority to overcome the insular disagreements and competing agendas and budget priorities that have thus far stymied, delayed, or diminished solutions.

TRICARE Standard vs. Prime Confusion. To at least some extent, healthcare access problems have been exacerbated by DoD and contractor emphasis on TRICARE Prime, to the frequent exclusion of any mention of the substantive differences between Prime and TRICARE Standard. Managed care contractors are paid to establish Prime networks, so “TRICARE” means only “TRICARE Prime” to many civilian providers and to many (especially currently serving) beneficiaries. That means many civilian providers have only known TRICARE as a program that requires them to accept discounted payments below Medicare rates. When TRICARE Standard beneficiaries go where they are directed to help them find providers – the contractor web sites – they see listings of only Prime network providers, whose appointments may be fully booked by Prime patients. But unlike Prime, TRICARE Standard does not entail any discount from Medicare rates. Once providers understand the difference, many who refuse to accept TRICARE Prime will accept Standard patients. The reality is most providers who accept Medicare (and the vast majority still do) also will accept TRICARE Standard, though some limit the numbers to a specific percentage of their practice. But better education on and articulation of the distinction between Prime and Standard, and more effort to help Standard patients find providers beyond the limited availability of the Prime network listing, would improve access among Standard beneficiaries. We very much appreciate the efforts the subcommittee has made to monitor and improve provider participation in Standard.

Mental Health Care. This subcommittee, DoD and others have gone to great lengths to ease access to mental health providers. Stigma remains a deterrent and will remain so as long as self-identification has a significant potential to result in loss of security clearance and/or dismissal from service. The situation is exacerbated by a nationwide shortage of psychiatrists and other mental health providers, and by a growing tendency among providers to opt out of accepting any insurance at all, requiring patients to pay high charges in full and file their own insurance claims for partial reimbursement.

Non-uniformity of TRICARE Prime. Establishment of different contractors for different TRICARE Prime regions has created problems for currently serving beneficiaries and others who relocate between regions. Aside from fundamental issues of transferring enrollment, each contractor has its own set of rules and policies that create inconsistencies between regions. The Coalition is grateful to the Subcommittee for the provision in the FY2016 NDAA aimed at reducing these inconsistencies and improving portability across TRICARE regions.

Rhetoric vs. Reality On DoD Health Care Costs

The Rhetoric. For years, Defense leaders have trumpeted dire statements to the effect military health costs are spiraling out of control. They’ve highlighted cost growth since the year 2000 and claimed that, if this trend continues, health costs will bankrupt the defense department or turn the Pentagon into merely a benefits delivery system.

Every year, in justification of such claims, Administration defense budget submissions show costs growing significantly in the outyears.

Many in the public, the media and the Congress understandably have accepted these claims at face value. One story begets another, and the cloud of such rhetoric has become self-perpetuating, with all the stories and quotes referencing each other as proof of the proposition.

The Military Compensation and Retirement Modernization Commission's review confirmed the reality belies the rhetoric.

The Background. While costs did grow over the first decade of the new century, this was because Congress made a conscious decision that the protracted and compounded pay and benefit cutbacks of the 1980s and '90s had gone too far.

On the healthcare front, hundreds of military hospitals and clinics had been closed during two rounds of base closures, and military beneficiaries over age 65 had been summarily locked out of virtually any military health coverage, leaving them only the same Medicare coverage available to any civilian who never served a day in uniform. The retired military community was understandably outraged at the wholesale breach of decades of promises that serving a multi-decade military career would earn lifetime military healthcare for themselves and their families and survivors.

As a result of this and a number of other pay and benefit cuts, retention and readiness was suffering in the late 1990s to the point the Joint Chiefs of Staff urged Congress to act on multiple fronts, including restoration of military health coverage for older beneficiaries.

That led to enactment of TRICARE For Life (TFL), effective in 2001, as second-payer to Medicare, provided the beneficiary enrolled in Medicare Part B. In doing so, Congress specified there should be no enrollment fee for TFL, in acknowledgement that qualifying beneficiaries had already earned/paid for this Medicare supplement coverage through extended and arduous service and sacrifice.

The TFL law also specified establishment of a TFL trust fund, through which the Treasury would fund the unfunded TFL liability for already-retired members, and the Defense Department would make actuarially determined annual deposits to the fund to cover the cost of providing future TFL coverage for members of the currently serving force.

Accordingly, the substantial cost of restoring coverage for the previously disenfranchised over-65 population reappeared in the defense budget, albeit in a new form (trust fund deposits). The change was lauded as both appropriate and needed, not only by the Legislative Branch, but by the new Administration entering office at the time.

Several years later, some of these same officials began looking back and expressing concern over the cost growth – as if anyone had actually expected restoring health and pharmacy benefits for nearly two million older beneficiaries would be cheap.

The Reality. DoD leaders in the intervening years began their “spiraling health costs” arguments with qualifiers like “if this trend continues.” But the trend was never going to continue. Enactment of TFL was a one-time change. The post-2000 growth trend would only continue if Congress approved a new TFL-equivalent program every few years.

While annual DoD budget submissions have continued to forecast substantial health cost increases in the outyears, those forecasts have proven consistently wrong.

When trust funds are first begun, the actuaries responsible for establishing the amounts to be deposited in the fund to cover future liabilities are necessarily very, very conservative, and the deposits started out quite large. But several years of actual experience with health costs for the TFL population have generated progressively more realistic actuarial assumptions, along with other initiatives, such as mandatory mail-order pharmacy use, that have dampened DoD costs.

Over the past six years, DoD costs for TRICARE For Life (i.e., trust fund deposits) dropped nearly 40%, and they are still falling, as indicated by the FY2017 budget.

	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17
DoD TFL Trust								
Fund Deposit	\$10.8B	\$11.0B	\$10.9B	\$8.5B	\$7.4B	\$7.0B	\$6.6B	\$6.4B

Costs for the DoD Unified Medical Program have declined/stayed flat for the last eight years.

	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17
DoD Unified								
Medical Prog.	\$49.9B	\$51.6B	\$52.9B	\$48.4B	\$49.3B	\$48.5B	\$47.8B	\$48.8B

DoD costs for purchased care have remained essentially flat for the last five years.

	FY10	FY11	FY12	FY13	FY14	FY15	FY16
DoD Purchased							
Care	\$14.3B	\$14.8B*	\$15.4B*	\$14.7B*	\$14.8B	\$14.8B	\$15.1B (proj)

*DoD actually underspent the budget in this account by a total of \$3.8B for FYs11-13.

Pharmacy costs have risen some, but should be moderated by copay changes and just-enacted expansion of mandatory use of the much-cheaper mail-order system.

	FY10	FY11	FY12	FY13	FY14	FY15
DoD Pharmacy						
Program	\$6.6B	\$7.0B	\$7.1B	\$7.1B	\$7.7B	TBD*

*One-time Rx costs are expected to be substantially higher due to a spike of gross overcharges for compounded medications, which DoD has since brought under control.

The other area of actual cost increases is the direct care system, which is under direct DoD control, addresses mainly readiness needs, and sees the fewest patients per provider.

	FY10	FY11	FY12	FY13	FY14	FY15
Direct Care Program	\$16.1B	\$16.9B	\$17.4B	\$16.1B	\$17.9B	\$17.6B

Health Costs in Perspective. Some defense leaders and others have stated, and continue to state, the military's health care costs absorb a "disproportionate" 10 percent, non-war share of the DoD budget. These assertions should be viewed in proper context in that healthcare costs comprise 23 percent of the nation's budget, 22 percent of the average state budget, 16 percent of household discretionary spending, and 16 percent of the U.S. gross domestic product. In this context, a 10 percent share of DoD's budget is not disproportionate, particularly when health costs over the last five years have remained flat.

MCRMC Proposals

The MCRMC advanced four over-arching proposals for significant changes to the MHS. We are generally in support of two of them but have significant concerns regarding the other two. **Extended Care Health Option (ECHO).** We applaud the Commission for addressing issues experienced by military families with special needs. We generally agree with the recommendations and the intent to improve support for these beneficiaries by aligning services offered under the ECHO program to those of state Medicare waiver programs. Guard and Reserve families are particularly vulnerable during transitional periods and should have an extension of support. It is imperative that the benefit must include members of all seven of the uniformed services.

DoD-VA Collaboration. We also support dramatically improving collaboration between the DoD and VA, and there exist some excellent examples of success, such as the joint DoD/VA health care facility in North Chicago. For years the Coalition has advocated for legislation to grant the existing Joint Executive Committee additional authority and responsibility to enforce collaboration. Many of the issues impeding progress, ranging from a common electronic medical record to joint facility and acquisition planning, can be accomplished in a transparent manner. Similarly, the issue of a transitional formulary for service members leaving the DoD and enrolling into the VA system should be immediately corrected. We're grateful the Subcommittee acted to address the latter issue in the FY2016 NDAA.

Joint Readiness Command. We have significant reservations the Commission proposal to create a new Joint Readiness Command (J-10) would create a new level of bureaucracy without addressing the fundamental issue of joint medical operations. ***The largest barrier to a truly efficient and highly reliable healthcare organization is the current three-service system organization.*** This arrangement is directly responsible for extensive costs through the duplication of technology services, medical equipment, lack of common procedures and

processes, especially in the much touted multi-service market areas. Literally millions are wasted each year due to the inefficiencies of this type of structure.

We believe there is an initial opportunity to test a unified budget/oversight concept in the large multi-service market areas (MSM's). An example is the military's integrated referral and management center which serves the multiple clinics and hospitals in the National Capital Area. It is charged with making specialty referrals and appointments for the geographical market area. However, they only end up making approximately 20 percent of the total appointments, due to the fact there is no unified policy and process in appointing beneficiaries into all of the military clinics and hospitals. The hospitals and clinics still report to three different service commands under three or more different sets of orders and varying budgets. This wastes millions in missed and untimely referrals.

A single budget authority, to include human resources and infrastructure oversight and control, will yield huge cost savings and efficiencies. Throughout the years, numerous studies have recommended the consolidation of medical budget oversight and execution, and this can be done while maintaining the readiness responsibilities of the Surgeons General under Title 10.

FEHBP-Style Replacement for TRICARE. In the belief the TRICARE system is irretrievably broken, the MCRMC recommended eliminating it and moving all beneficiaries except those over age 65 and active duty members into a commercial premium-based insurance model, similar to the Federal Employee Health Benefit Program (FEHBP). The new program, called TRICARE Choice, would offer beneficiaries an array of plan options to choose from based upon their location. MTFs would be offered as one of the providers in the plan. It is envisioned DoD would have the authority to adjust MTF billing for civilian reimbursements and co-payments for insurers as needed to meet the MTF's readiness requirements.

The Coalition is not convinced TRICARE is unfixable or that this radically different concept would sufficiently support military readiness, particularly if DoD moves away from the three-service structure to a unified system of managing and budgeting for health care. One principle we have endorsed is providing a uniform benefit for equal service. Because military families endure frequent locations and military beneficiaries are dispersed across the country, we have concerns about imposing a system that inherently entails different costs and benefits for different localities.

The Commission proposes leaving the TRICARE pharmacy program unchanged. But virtually all FEHBP plans include levels of pharmacy coverage, and practical experience is the TRICARE pharmacy program is virtually unusable if other coverage exists. The Coalition believes this would entrap military families between significantly higher costs for civilian coverage or extraordinary bureaucratic problems if they seek to use TRICARE pharmacy programs.

The needs of a military family today can be dramatically changed by the demands of service. It is not clear that the wide variety of commercial plans under an FEHBP-like scenario would be sensitive to or responsive to a military family's unique needs. *"Ready to Serve,"* the title of

MOAA and United Healthcare Foundation's survey on civilian providers, conducted by RAND and released in December 2014, shows civilian mental health providers are not equipped with the necessary knowledge or cultural sensitivity required in the care of military and veterans populations. Applied Behavioral Analysis therapy that Congress has worked to authorize for military families with autistic children, is generally not provided for in FEHBP plans.

Putting this major military health benefit under the administration of the Office of Personnel Management (OPM) appears to be a significant step toward treating military beneficiaries like federal civilians for health care purposes. Military beneficiaries incur unique and extraordinary sacrifices unlike the service conditions of any civilian, and their health benefits have been intended to be significantly better than civilian programs.

An additional concern centers on the potential premium working-age retirees would pay. The Commission-proposed 20 percent premium cost share is substantially too high in our view, regardless of any phase-in period. A 20 percent cost share is not far off from the 28 percent cost share for federal civilians using FEHBP. Military retirement and medical benefits are the primary offset for enduring decades of arduous service conditions. Career retirees pre-pay huge "up front" health care premiums through 20 to 30 years or more of service and sacrifice, and this needs to be better recognized in the level of cash fees they pay.

Those concerns all stated, the Coalition could support testing the MCRMC-proposed system for drilling and gray-area Guard/Reserve beneficiaries who are, in fact, significantly disadvantaged under current TRICARE programs. An FEHBP-style system, appropriately subsidized, could well be an improvement over the inconsistent TRICARE coverages and fees currently experienced by Guard and Reserve beneficiaries under age 60. We must note, however, that military technicians who are restricted to FEHBP coverage have complained for years that they would prefer to have access to TRICARE Reserve Select coverage at much lower, subsidized premiums.

Key Principles

The Coalition believes healthcare adjustments going forward should take into account the following key principles.

Maintain and Improve Readiness. No other healthcare system has the dual role of supporting warfighting capabilities and serving the broad spectrum of beneficiary needs and interests. Readiness includes more than care for currently serving personnel. Sustaining needed care and access for family members directly affects the readiness of the servicemember. There is also a vital readiness element to maintaining a retirement benefits system strong enough to help sustain career retention, even in the face of protracted war and multiple deployments.

Fees Must Appropriately Reflect Pre-Paid Premium Value of Career Service/Sacrifice. Nothing is more inappropriate than a simple comparison of cash fees paid by military vs. civilians for healthcare. For a true appreciation of what career servicemembers and their families pay, one

should ask the civilian if he/she is willing to visit a recruiting station and sign up for two or three decades in uniform, with the potential to spend two or three or more of those years in a war zone. Only then does one appreciate how steep a pre-paid premium is extracted over a career of service and sacrifice in uniform. This is the fundamental point of military service organizations' opposition to past steep fee increases proposed by the Defense Department "to better reflect civilian practice." ***Simple comparisons of military vs. civilian cash fees fundamentally devalue servicemembers' and their families' decades of service and sacrifice for America.***

Means-Testing Is Inappropriate for Military Health Benefits. Proposals to vary military retiree healthcare fees based on grade, retired pay, or other measure of income deny the service-earned nature of the benefit. Such practices are nearly unheard of in any other employer-provided health coverage. The President, Secretary of Defense, Senate Majority Leader, and Speaker of the House are eligible for the same federal health benefit and premiums as the lowest-grade federal civilian retiree. Means-testing of service-earned benefits would progressively and perversely reduce benefit value the longer and more successfully a uniformed person served. That is not an appropriate career incentive structure.

No Enrollment Fee for TRICARE For Life or TRICARE Standard. An enrollment fee is reasonable for a managed care plan like TRICARE Prime, which (at least nominally) guarantees access to care within certain standards. The Coalition strongly opposes an enrollment fee for TRICARE Standard and TRICARE For Life, which offer no such guarantees. In the case of TRICARE for Life, Congress expressly prohibited an extra enrollment fee, in recognition TFL-eligibles must pay an enrollment fee to Medicare as first payer, and DoD is only liable for the beneficiary's Medicare cost-share. In the case of TRICARE Standard, beneficiaries already are liable for a 25% cost-share.

Beneficiaries Should Not Be Compelled to Forfeit Service-Earned Coverage. In previous years, there have been proposals from the Pentagon and elsewhere to limit TRICARE eligibility for working-age retirees with access to employer health plans. Other proposals envisioned requiring an explicit annual enrollment in TRICARE Standard (with or without an enrollment fee) and denial of care to those who failed to enroll. Others (including the FY17 budget proposal) would force an annual choice for dual-eligibles between DoD- and VA-provided care. The Coalition strongly believes all such proposals are inappropriate. DoD actively promotes retention by emphasizing that career service earns lifetime health care. Nowhere in retention materials has there ever been a caveat – nor should there be – that adds "unless you take post-service employment with some kind of health benefits." Dual VA and DoD eligibles may be willing to drive 100 miles to a VA facility to see a spinal or other specialist for service-caused conditions, but still should be able to use local providers for routine and urgent care. Similarly, arguments that DoD needs annual enrollment to project costs are patently spurious. DoD already knows exactly who is in its beneficiary pool by virtue of their military ID cards, and has detailed history of every beneficiary's TRICARE treatment and cost. The only practical effect of an annual enrollment requirement would be denial of needed care for beneficiaries who didn't get the word or otherwise overlooked the required enrollment date.

Readiness Costs Should Not Be Passed to Beneficiaries. The Coalition strongly agrees with the MCRMC proposal to strictly separate readiness-driven medical costs from those attributable to benefits for beneficiaries. The costs of maintaining readiness are necessary costs of doing business. One of our great frustrations has been the lack of transparency of DoD assertions about what share of DoD costs are borne by beneficiaries. The Coalition does not accept any such assertions without transparency of what costs are included in the denominator of the fraction.

When military providers are deployed in wartime and more beneficiaries are forced to civilian providers, the Coalition views those increased costs as directly due to readiness requirements. Attributing them to beneficiary benefits is no different than attributing battlefield care as benefits. Similarly, *when the military healthcare system is deliberately or inadvertently inefficient (such as maintaining three separate military delivery systems, having military providers see significantly fewer patients per day as civilian providers, or having sequestration-driven hiring freezes that drive more patients to private sector providers), the resultant higher cost of care cannot be considered as having any benefit value. The extra costs result purely from the way the military or the government chooses to do business, and often result in extra cost-shares for beneficiaries, too.*

No User Fee/Copay for MTF Care. The Coalition believes virtually all care provided in military facilities should be deemed readiness costs. That, after all, is the primary reason for maintaining these facilities, and the reason DoD wishes to capture care in the facilities is to ensure military providers have enough practice to maintain their professional skills. Any benefit value associated with in-house care is ancillary to the main readiness purpose. For this reason, the Coalition vigorously opposes imposition of any copays or user fees for in-house care.

Fees Should Not Be Set in Ways That Deter Care-Seeking. When the Defense Department first proposed substantial increases in TRICARE fees, an express part of the rationale and the associated savings was to drive some beneficiaries away from using their military health coverage. Others have asserted military beneficiaries use more healthcare than civilians do, and proposed higher fees so military beneficiaries would have “more skin in the game” and presumably be more hesitant to seek care. One concern the Coalition has with recent substantial increases in pharmacy copays is that past studies have shown higher copays deter patients with chronic conditions from seeking care or filling their prescriptions. We believe strongly in positive incentives to encourage beneficiaries to seek needed care in the most appropriate venues. We do not support imposing fees to deter use of their service-earned benefits.

Military Health Benefit Should Be “Gold Standard”. The Coalition agrees with the many, many DoD and other government leaders who have said the military health benefit should be second to none. Those who spend decades subject to being put in harm’s way deserve no less. This is another reason why we object to fee increases based on rationale that the result would be

more in line with private sector practice. Military benefits are not supposed to be “more in line with” or “somewhat better than” civilian benefits, but very substantially better.

Each similar group of eligibles should be provided similar health coverage. We are not in favor of an FEHBP-style system that means those with more income can buy better coverage. We make an exception in the case of Guard/Reserve coverage mainly because, our concerns aside, the MCRMC-recommended option offers an improvement in continuity of care and consistency of coverage over the wildly inconsistent programs now in effect for this population.

We Don’t Need Another Trust Fund. When Congress established a trust fund for TRICARE For Life in 2001, its stated intent was to ensure the program would always be fully funded. That was a laudable intent, but the process created a significant practical drawback. Under congressional budget rules, any law change that increases trust fund spending is considered mandatory spending. That means the Armed Services Committees cannot make even the slightest needed adjustment to TFL coverage without being forced to make an equivalent cut elsewhere in TFL, military retirement, or survivor benefits to pay for it. This is true even if the change would save money in the long run. For example, when this Subcommittee initiated a requirement for the defense department to initiate wellness programs (e.g., paying for smoking cessation programs), you were forced to exclude TFL-eligibles. So for lack of a small short-term funding need, DoD and Medicare will be hit with larger, longer-term smoking-related care bills.

Some have proposed establishing a trust fund to cover the cost of care for beneficiaries under age 65. The Coalition strongly opposes doing so, based on the TFL experience that it would bring inflexible rules into play that prohibit almost any program improvements, even those that would be very beneficial for the government in the long term.

Health Care Benefits Should Apply Equally to All Uniformed Services. Too often when healthcare and certain other legislation is being drafted to improve one program or another, its language includes the term “Armed Forces.” Use of this terminology inadvertently omits two of the seven uniformed services – the commissioned corps of the US Public Health Service (USPHS) and the National Oceanographic and Atmospheric Administration (NOAA) – from coverage. All seven uniformed services fall under the purview of title 37 and title 10 of the United States Code, and the clear objective is to provide members of all seven services the same pay, allowances, and benefits under these titles.

Wounds/Injuries Should Not Cause Extra Beneficiary Costs. Never is the sacrifice inherent in military service so clear as it is in time of war. The Coalition believes strongly that no military beneficiary should have to incur higher health costs simply because that very service caused the member to become disabled. The clearest example of this is the young warrior who is so wounded, ill or injured as to become totally disabled and eligible for Medicare. Under current law, TRICARE is second payer to Medicare, and any Medicare-eligible must enroll in Part B...and incur at least the current \$105 monthly (\$1,260 annual) enrollment fee. Had the member not become disabled, he or she would not have been required to incur this fee until age 65.

Recommendations

Preserve What Works Well, and Focus on Fixing Problem Areas. The Coalition fully understands there are many programs that would look much different than they do today if we were starting from scratch to design them. But the practical reality is we are not starting from scratch. The challenge is working out how we can get to where we want to be -- starting from where we are today. It's tempting for critics to say "toss the whole system out and start over." But the critics are rarely the people who have to take responsibility for continuing to carry out the current mission while changing systems to meet tomorrow's needs. Radical overhauls have their own high potential for unintended consequences. In that regard, the Coalition is not convinced TRICARE is so irretrievably broken that it must be discarded entirely.

Provider Payments Should Reward Quality Care. Any number of studies have identified the shortcomings of fee-for-service payment programs, including TRICARE. The Coalition concurs with the MCRMC belief that both Medicare and TRICARE need to move to payment systems and treatment bundles that reward providers for meeting standards of quality and healthy outcomes rather than simply paying them for the number of patient encounters they have.

Focus on the Causes of Problems, Not the Symptoms. The mere fact a particular beneficiary cost is rising doesn't mean the beneficiary had a hand in raising the cost or that the solution is to make the beneficiary pay more. This is particularly true if the real reason behind the cost increase is program inefficiency, DoD or service decision-making, the exigencies of national conflict, or arbitrary hiring freezes or other conditions caused by sequestration. The solution should be to focus on addressing those problems rather than making beneficiaries pay more simply because it's budgetarily or programmatically easier.

Consider Implementing a MCRMC-Style Insurance System for the Guard/Reserve (G/R). First of all, the current hodgepodge of makeshift healthcare programs for the under-60 G/R community makes it one program where it actually is possible to start over from scratch. Second, the current G/R systems are not meeting the needs of the majority of G/R beneficiaries. Third, the subsidy levels envisioned by the MCRMC would provide a better deal for many G/R beneficiaries than they have today -- especially "gray area" retirees and those drawing retired pay before age 60 because of deployment credit, who now have no subsidized care. Part and parcel of this change would be giving Selected Reservists who prefer to keep family coverage through an employer the opportunity to retain that coverage upon activation, with the premium paid or subsidized by DoD.

Consider Establishing a Joint SASC/SVAC Subcommittee on DoD/VA Transition. Many of the problems with this transition stem from the two departments' separate funding priorities...which also reflect in some measure the views and priorities of their respective oversight committees on the Hill. If the SASC and SVAC can cooperate in a joint subcommittee -- even a temporary one -- to devise joint policy, program, and budget solutions on such issues as a joint interoperable electronic healthcare record, there is a far greater chance this joint resolve can be reflected in DoD and VA programs.

Require DoD to Implement the MCRMC Recommendation to Expressly Allocate Readiness and Benefit Costs. A thoughtful and rational dialogue on beneficiary cost sharing absolutely requires an agreement on exactly which expenses are a cost of doing national defense business vs. a benefit value delivered primarily for the sake of the beneficiaries. This in itself is purely an accounting change so all parties can be on the same page in assessing readiness vs. benefit costs and from there assessing what is a reasonable cost-sharing mechanism for beneficiaries.

Seek Some Form of Agreement on the Premium Value of a Service Career. This issue is at the crux of every disagreement between DoD and its beneficiaries over how much the latter should be expected to pay for their healthcare benefits, and why. The legislative history of CHAMPUS, TRICARE Prime, and TRICARE For Life allows at least some starting inferences on this thorny topic. We understand some may wish to avoid any explicit valuation, lest future conditions require a change. From the Coalition's standpoint, that's one important reason at least some general agreement should be established. The problem is that beneficiaries remember what they were told and must adapt to and live with what they were told. Executive and Legislative Branch officials and military leaders, by contrast, change every few years and their views are driven more by current budget conditions than past history. A primary reason for beneficiary outrage at proposals for steep fee increases are current-year assertions that military beneficiaries are somehow undeserving of current benefit levels or that their benefits should be more like civilians'. Such arguments fly directly in the face of what the military retirees were told in order to induce them to stay for a career in uniform. Acknowledging what retirees were promised doesn't mean current circumstances will never change, or that some changes might be needed in the future. ***But coming to at least some kind of general consensus on what constitutes an appropriate service-earned differential will serve several important purposes from beneficiaries' standpoint.*** First, it will offer a public and verifiable acknowledgement of the promises used to induce them to serve decades in uniform despite the extraordinary sacrifices involved, so these can't be denied or dismissed by future leaders. Second, it hopefully will give at least some degree of pause to those who want to change the rules retroactively, and cause a conscious consideration of what kind of grandfathering might be feasible. Finally, in the event some particularly difficult cutback cannot be avoided in the future, it would hopefully increase the chances the change would at least be accompanied by an apology rather than infuriating assertions or implications that military retirees didn't earn and don't deserve the existing level of benefit.

Test the Concept of Unified Budget and Oversight Authority in MSMs. The Defense Health Agency is in an excellent position to oversee establishment of pilot project to test the concept of a single budgetary/operations oversight authority in at least two of the multi-service market areas (MSMs). Such a test should offer some insight into the feasibility and potential savings associated with unified vs. multiple-service oversight of budget, appointing/referral, and other operational and support programs. The Coalition believes this issue is important enough that it should be pursued at the earliest possible date.

Promote More Balanced Patient-to-Provider ratios in MTFs. Undertake efforts to assess and change support staffing and other factors that lead military providers to see significantly fewer patients per week than their civilian counterparts. If, as defense health officials often assert, it is more cost-effective to see beneficiaries in MTFs, it should be worthwhile investing in whatever is necessary to promote a more balanced patient-to-provider ratio. This should also substantively ease the appointing and referral problems reported by Prime enrollees.

Require Leadership Oversight/Training on Appointment Timeliness. It is beyond understanding that the TRICARE Prime appointment process apparently ignores DoD access standards on a routine basis at many facilities. This is in substantial measure a leadership problem, in the Coalition's view. To the extent such action hasn't been taken already, there should be a full retraining of all involved in the appointing process that appointments that cannot be made in the MTF within DoD timeliness standards must be offered a civilian provider appointment within those standards. It also should be made clear to MTF commanders and others in leadership positions over appointing offices that it is their responsibility to monitor appointment timeliness and take necessary corrective action when standards are not being met.

Focus Managed-Care Outreach Efforts on High-Use/Cost Beneficiaries. Under current rules, priority is given in MTFs to active duty members and families, TRICARE Prime enrollees, other under-65 beneficiaries, and TFL-eligibles, in that order. TRICARE Prime is mostly focused on beneficiaries who live within 40 miles of an MTF. The Coalition believes first priority for managed care or case management should be given to beneficiaries with a history of high-cost care and those with chronic conditions that have the greatest potential for incurring high costs in the future. For example, a TRICARE Reserve Select family with multiple children requiring complex care would have a high incentive to be seen in a managed-care environment, but is not eligible for Prime enrollment. Similarly, certain TFL-eligibles or other non-Prime enrollees may have chronic conditions posing long-term cost risks far higher than a majority of Prime enrollees. These high-cost care users are readily identifiable from existing cost records. Surely there are savings to be realized by shifting to include a care-cost factor and creating outreach programs to bring such families into a more active managed-care or case management system.

Pursue Public-Private Partnerships to Reduce TFL and Other Costs. Several innovative cost-saving programs around the country have potential application to military beneficiaries and facilities. The Coalition would encourage DoD to investigate the potential for partnerships with civilian contractors to establish TFL-specific Medicare Advantage programs in locations where there are large retiree populations and significant military medical facilities. The partnership agreement would establish the military facility as the preferred provider for certain surgeries or other conditions to help sustain military providers' readiness skill levels. These programs should include outreach efforts to identify high-cost users and those with chronic conditions to bring them into a case management environment. This system would reduce the contractor's cost and allow addition of other program elements (e.g., vision or dental) to incentivize TFL-eligibles' participation. The military facility, in turn, could be reimbursed at some level through the TFL trust fund. This would seem to have a winning potential for the government, DoD, contractors,

and beneficiaries alike. Anthem's Care More program is an exceptional and proven model, and Humana and United Healthcare offer similar programs. The MCRMC staff cited another successful model in the Las Vegas area.

Adopt pediatric-centered payment policies that let providers make optimal care decisions for children. Because TRICARE payment systems are based on Medicare systems designed for older people, the systems often don't work for pediatric care and don't properly reimburse providers for needed and delivered care. Reimbursement should follow appropriate care, not form the basis for care decisions. In situations where emerging technology is clearly providing compelling options for patients and families, TRICARE should allow payment to follow the needs of the patient instead of driving the type of care the patient receives. When there is a known issue with translation of policy or payment from Medicare to pediatrics, there must be an efficient process for resolving the difference. Continued innovation and research will ensure this issue is at the forefront in the coming years, with genetic testing, gene therapy, and individualized medicine as examples of prevention, intervention, and treatments that will need to be covered and reimbursed appropriately.

Do More to Connect TRICARE Standard Beneficiaries with Providers. One way to improve TRICARE Standard beneficiaries' access to providers is to educate them that they are not limited to seeing network providers. It's preferable if they do, because that saves money for both DoD and the beneficiary. But if a beneficiary is having trouble getting an appointment with a network provider, there should be a method to put them in touch with a non-network provider who is willing to accept non-discounted rates payable under Standard. We understand there is little incentive for current managed care contractors to facilitate use of non-network providers. We appreciate this Subcommittee's efforts to require DoD surveys of provider participation in Standard, and to establish measures of provider participation by locality. The next logical step is to require DoD to establish participation thresholds below which DoD must take direct efforts (through higher payments or other methods) to increase provider participation to levels consistent with healthcare needs of active duty, Guard/Reserve, and retired beneficiaries residing in that locality.

Ease the Cost Burden on TRICARE Young Adult (TYA) Beneficiaries. Unlike civilian insurance programs, which spread the cost of adding children under 26 by raising family premiums slightly across the board, TYA requires each TYA-eligible (or the parents) to pay the full individual premium cost of his or her care. With the 26% (TRICARE Standard) and 47% (Prime) premium increase for 2016, the \$2,500 to nearly \$3,700 annual cost of this program is particularly onerous, especially for families with more than one qualifying child. The Coalition encourages the Subcommittee to explore alternative ways to spread this cost across the entire beneficiary population, in hopes this could be done via a relatively inconsequential increase. As currently implemented, the high individual cost of the coverage deters many beneficiaries from using it, which defeats the purpose of the program.

FY2017 DOD Budget Request Health Care Reform Proposals

The Coalition is disappointed the FY17 defense budget provides only vague statements on planned program improvements, but focuses specifically on adding several new fees and raising a wide array of others, especially for the retired community.

In addition, it would require formal enrollment for DoD care, or coverage would be denied for the year.

The proposal does appear to offer somewhat lower costs for currently serving beneficiaries, but would significantly complicate healthcare programs by renaming them, creating a new network system, and instituting a complex system of different copays for different kinds of services, with different charges for in-network and out-of-network services.

The budget proposals do nothing to resolve inconsistent programs for Guard and Reserve members and families, do not address the discontinuity of care between mobilization and demobilization, and places them at risk for even higher out-of-network fees for those who don't live near military installations or heavily populated areas.

The proposals would require retirees to pay more for care, and more rapidly escalate those charges in the future, without any assurance of improved access, quality, or wait times. The proposals offer very little specifics, or committed resources, on how the Department will improve military health care or increase its value.

Proposed Reforms That are Favorable

Aspects of the proposed budget which appear favorable in concept center on the issues of access to care and ease of referrals. The budget itself does not indicate much detail, or offer additional resources, but indicates MHS leaders have pledged to bridge gaps and fix problems by instituting and changing existing structures through:

- Issuing MTF appointments on the first call by the beneficiary
- Streamlining the specialty referral process
- Working to improve continuity of care with providers
- Increased Telehealth capabilities
- Improving services for military children
- Reforms to the Patient Centered Medical Home, to include extending hours
- Monitoring beneficiary satisfaction with access to care as the metric for success

Additionally, the proposed lower inpatient copays for TRICARE Standard/Choice and a fee structure which supports active duty military families are improvements. Active duty service members and their families do well, especially if they choose the MTF centric option, and would

have no copayment for receiving care in network with a referral, and will have no charge for utilizing an urgent care center or an emergency room.

Areas of Concern on FY17 Budget Proposals

The budget proposes reconstituting TRICARE into two renamed options: TRICARE Select (currently the HMO-MTF centric option, TRICARE Prime) and TRICARE Choice (currently TRICARE Standard and Extra).

TRICARE Select beneficiaries would pay reduced fees and co-payments, and would use primarily military hospitals and clinics. Enrollees in this option would have no cost sharing for care received in those locations. DoD hopes to drive down expenses with this option because it costs DoD less when beneficiaries use military treatment facilities (MTF) compared to receiving civilian care. The reduced cost structure is also designed to incentivize beneficiaries to obtain their care in the MTFs with the goal of maximizing MTF use and enhancing training/professional skills of military providers.

The Coalition concurs with the goal but remains deeply concerned regarding the MTFs' ability to absorb new beneficiary demand with existing capacity. Inflexible appointing processes, readiness requirements and provider un-accountability for open appointing practices all serve to undermine a MTF or clinic's capacity. It's one thing to say those chronic problem areas will be fixed; it's another thing entirely to ensure those fixes are implemented successfully. The Coalition is very concerned these proposals are built upon so-far-unfulfilled commitments to fix them.

The second option, **TRICARE Choice**, would provide an un-managed plan for the largest share of beneficiaries. It proposes to arrange for PPO-style provider networks, with the stated goal of establishing networks sufficient to provide care for 85% of participating beneficiaries. This arrangement poses the most risk for those in rural areas, including many Guard and Reserve members and families.

In regard to fee and co-payment adjustments, DoD's budget hits retirees under age 65 the hardest, by charging steep enrollment fees for participating in either TRICARE option.

Retirees would be charged an annual enrollment fee of \$350 for an individual or \$700 for a family using TRICARE Select, **a 24% increase from the current fee**. TRICARE Choice – or Standard, which currently has no enrollment fee – would require a \$450 fee for individual coverage and \$900 for families, and still would provide no guaranteed access to care. Of particular concern, the TRICARE program has had a long history of providers reluctant to accept TRICARE's lower reimbursements. This poses significant questions regarding how robust the PPO networks would be.

TRICARE for LIFE (TFL) beneficiaries would also see controversial increases under the budget proposal. For the first time, new TFL entrants as of 1 January 2017 would be required to pay an

enrollment fee. The Coalition believes enrollment fees should be reserved for programs like TRICARE Prime, which guarantees access.

Of particular concern, TFL beneficiaries would also be subjected to means-testing, with fees initially set at 0.5% of retired pay, rising to 2% of retired pay for a TFL-eligible couple, to be phased in over 5 years. It would be accompanied by a complicated system of fee caps, one for flag officers and one for lower grades. The Coalition does not support means-testing, which imposes financial penalties for longer and more successful service on a population that is already paying the highest fees of any military beneficiaries. ***The Coalition believes strongly in the original intent of Congress, which expressly prohibited a separate enrollment fee for TFL, acknowledging this group already incurs higher costs than other military beneficiaries by virtue of being required to pay Medicare Part B premiums. The proposed new fee is particularly inappropriate since DoD's costs for TFL have declined precipitously, from \$11 billion in FY11 to an estimated \$6.4 billion in FY17.***

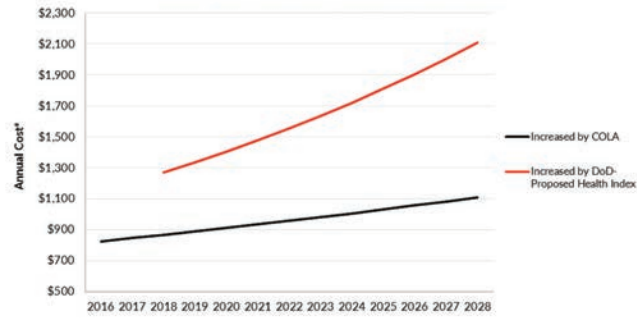
Raising the catastrophic cap (maximum out-of-pocket expenses) to \$1,500 per year for currently serving families and \$4,000 for retired families (vs. current \$1,000 and \$3,000)

Pharmacy co-payments would double over ten years. The budget proposal creates a multi-year schedule which would double most pharmacy copays, which have increased five-fold over the recent few years. In many cases, current copayments already are at or above corporate insurance medians.

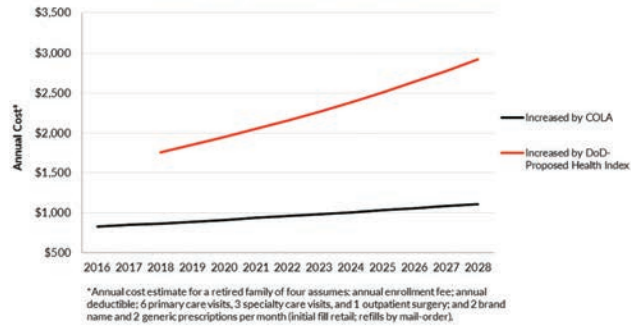
Indexing fees to medical inflation is another key component of the DoD proposal. It would provide for annual adjustments of the aforementioned fees and co-payments to the national health expenditure index, which is projected to rise at 5.2% per year. This is noted in the budget in small print – but has very large ramifications for beneficiaries. It would result in both active duty family and retiree co-payment increases of nearly 50% by 2025. This growth rate is significantly faster than the growth in TRICARE payments to providers, which means beneficiaries paying flat fees (rather than the current 20% or 25% of TRICARE-approved charges) likely would end up paying ever-increasing shares of TRICARE-approved charges.

The following charts illustrate how the new proposals would not only impose a significant fee increase immediately, but would rise dramatically in the future compared to current COLA-based adjustments.

**TRICARE Prime fees (In-Network):
COLA vs. National Health Expenditure**



**TRICARE Standard fees (Out-of-Network):
COLA vs. National Health Expenditure**



The Coalition believes strongly that military beneficiary fees should not grow faster than their military compensation does. We agree with the methodology previously approved by this committee that annual increases should not exceed the percentage growth in military retired pay (i.e., inflation as measured by the Consumer Price Index).

The Coalition also is concerned that many cost-shares that are now expressed as a percentage of the TRICARE-approved provider payment would be converted to flat fees, and then adjusted annually by the 5.2% annual health index. The reality is that Medicare-based payments to providers have increased very modestly over the years as Congress has sought to keep Medicare costs down. Assuming this trend will continue, the proposed schedule would steadily increase the patient's relative share of the payment. The following chart shows how this would happen, assuming a 5.2% increase in the flat-fee cost-share vs. a 1.5% annual increase in TRICARE payments to providers (which is actually more than payments have increased over the past decade).

	TRICARE Pays Dr	Patient Pays*	Patient Cost Share
2018	\$ 100	\$ 25	25%
2019	\$ 102	\$ 26	26%
2020	\$ 103	\$ 28	27%
2021	\$ 105	\$ 29	28%
2022	\$ 106	\$ 31	29%
2023	\$ 108	\$ 32	30%
2024	\$ 109	\$ 34	31%
2025	\$ 111	\$ 36	32%
2026	\$ 117	\$ 40	35%
2027	\$ 120	\$ 43	36%
2028	\$ 122	\$ 46	37%

*If adjusted by annual National Health Expenditures index (5.2%/year) as FY17 budget proposes

Imposing an annual enrollment requirement and denying care to those who don't enroll is a key element of the FY17 proposal. According to DOD, failure to explicitly opt in during an annual open enrollment would eliminate coverage for the beneficiary and family for that year. The Coalition strongly opposes this requirement, which effectively would deny a service-earned healthcare benefit. As outlined above, some members may find it preferable to use VA facilities for certain care, but use their earned TRICARE benefit for family care. Others may use spousal or employer insurance for certain care, but TRICARE for things the other insurance doesn't cover. The DoD argument that it needs to be able to plan for who will use DoD care is spurious. DoD knows every claim and every penny spent on each eligible TRICARE beneficiary, and has full capacity to track trends and make future projections. The fact DoD healthcare costs have been flat and DoD is typically able to reprogram funds at the end of the year provide ample evidence of that. The practical reality is Standard beneficiaries are used to just showing their ID card as proof of eligibility. Many would discard notices of a requirement to enroll, especially in the first year, assuming it was junk mail. The consequences in some cases would be far worse than being told at a medical appointment they are not covered. The first time some sponsors could learn of the requirement is upon having a family member suffer a potentially life-threatening injury/illness or require an extended hospital stay, and find they are denied coverage for failure to enroll. That should be an intolerable scenario for DoD as well as the beneficiary. ***In the Coalition's view, no eligible beneficiary should be denied their service-***

earned healthcare coverage. If there is to be an enrollment requirement, any eligible beneficiary should be enrolled automatically upon seeking care. As it has for decades, the military ID card should serve as proof of enrollment.

Net Impact of DoD-Proposed Fee Changes on Military Families

The complexity of the proposed fee changes can be bewildering, especially since all of the program names would be changed as well. The actual impact of the changes on military families could vary widely, depending on the family's usage of various kinds of care.

The following charts show how the changes would affect typical currently serving, retired families under age 65, and Medicare-eligible families compared to the fees they pay in 2016, assuming a specific set of provider visits and prescriptions. For the sake of simplicity and transparency, the charts use the current program names.

In general, the changes would be financially beneficial for active duty families, but far less so for Selected Reserve families.

The changes hit retired families under age 65 the hardest, imposing increases of 50% or more for those using in-network providers and 100% increases for those who don't -- or can't -- use network providers. The Coalition believes these fee increases are disproportionately high, especially when there are no guarantees of improved access or service.

Currently Serving - Family of Four			
Fee Component	2016 TRICARE Standard	2018 TRICARE Prime	2018 TRICARE Standard
Enrollment Fee	\$0	\$0	\$0
Deductible ¹	\$300	\$0	\$0
Network Copays ²	\$0	\$0	\$195
Rx Cost Shares ³	\$188	\$76	\$76
Yearly Total	\$588	\$76	\$271

¹ Under proposal, general deductibles apply for out of network care only

² Assumes 5 network visits per year (3 Primary, 2 Specialty Care, 2 Urgent Care, 1 ER)

³ Assumes 2 brand name and 2 generic prescriptions per month (initial fill retail; refills by mail-order)

Source: FY17 President's Budget Request

TRICARE Prime ¹ - Retiree Family of Four			
Fee Component	2016	2018 In Network	2018 Out of Network
Annual Enrollment Fee	\$565	\$700	\$700
Annual Deductible	None	None	\$600
Doctor Visit Copays ²	\$72	\$310	--
Rx copays ³	\$188	\$260	\$260
Yearly Total	\$825	\$1,270	\$1,560

TRICARE Standard ¹ - Retiree Family of Four			
Fee Component	2016	2018 In Network	2018 Out of Network
Annual Enrollment Fee	None	\$900	\$900
Annual Deductible	\$300	None	\$600
Doctor Visit Copays ²	\$338	\$265	--
Rx copays ³	\$188	\$260	\$260
Yearly Total	\$826	\$1,425	\$1,760

¹ Under proposal, TRICARE Prime will be known as TRICARE Select, and TRICARE Standard will be known as TRICARE Choice

² Assumes 6 primary care visits, 3 specialty care visits, and 1 outpatient surgery.

³ Assumes 2 brand name and 2 generic prescriptions per month (initial fill retail; refills by mail-order)

Source: FY17 President's budget request

TRICARE For Life - Married Couple		
Fee Component	2016	2018
Annual Medicare Premium ¹	\$2,520	\$2,570
TFL Enrollment Fee ²	None	\$300
Rx copays ³	\$376	\$520
Yearly Total	\$2,896	\$3,390

¹ Assumes 1% annual COLA. Medicare premium based on lowest income bracket fee, many pay more.

² O-5 with 20 years of service turning 65 in 2018 (fee would double by FY2021)

³ Assumes 4 brand name and 4 generic prescriptions per month (initial fill retail; refills by mail-order)

Source: FY17 President's budget request

Mr. Chairman, Madam Ranking Member, and members of the Subcommittee, thank you for this opportunity to present our inputs on these important issues. We stand ready to work with you and your staff in any way that would be helpful.

